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ABSTRACT

The major goal of this TIP, on the best practice guidelines to improve the treatment of substance abuse, is to provide clinicians, educators, and paraprofessionals with the latest findings concerning domestic violence. The information is intended to educate providers about the needs and behaviors of batterers and survivors, and how to tailor treatment plans accordingly. The focus is on men who abuse their female partners and women who are battered by their male partners. It reports that up to one half of the men who commit acts of domestic violence also have substance abuse problems. Failure to address domestic violence issues among substance abusers can interfere with treatment effectiveness and contribute to relapse. Chapters include information on the survivors of domestic violence, screening and referral of survivors and batterers for additional services, legal issues, coordinated community linkages, and a summary of recommendations. It states that teaching decision-making skills to both the men and women involved in domestic violence is a key aspect of treatment. Appendixes include: "Bibliography," "Federal Confidentiality Regulations," "Instruments," "Sample Personalized Safety Plan for Domestic Violence Survivors," "Hotlines and Other Resources for Domestic Violence and Related Issues," "Resource Panel," and "Field Reviewers." (Contains approximately 200 resources.) (JDM)

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Substance Abuse Treatment and Domestic Violence

Treatment Improvement Protocol (TIP) Series

25

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HOTLINES

National Domestic Violence Hotline
Suite 101-297
3616 Far West Blvd.
Austin, TX 78731-3074
(800) 799-SAFE
(800) 787-3224 (TDD)
Provides crisis intervention, information about sources of assistance, and referrals to battered women's shelters.

Rape, Abuse, and Incest National Network (RAINN)
(800) 656-4673
Sexual assault survivors who call will be automatically connected to a trained counselor at the closest center in their area.

Childhelp USA/Forrester National Child Abuse Hotline
(800) 4A-CHILD
With a focus on children and the prevention of child abuse, this hotline provides crisis counseling, referrals, and reporting guidance to callers in crisis. Statistical and other informative materials can be ordered through this number. *Access to information on partner violence is limited.*

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National Clearinghouse on Child Abuse and Neglect
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Washington, DC 20013-1182
(800) FYI-3366
(703) 385-7565
(703) 385-3206 (fax)
nccanch@calib.com

National Coalition Against Domestic Violence
P.O. Box 18749
Denver, CO 80218
(303) 839-1852
(303) 831-9251 (fax)

National Victim Center (NVC)/INFOLINK
(800) FYI-CALL
(703) 276-2880
www.nvc.org

Family Violence and Sexual Assault Institute
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Tyler, TX 75701
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fvsai@e-tex.com

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Substance Abuse Treatment and Domestic Violence

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What topics would you suggest for future TIPs?

____

____

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Substance Abuse Treatment and Domestic Violence

Treatment Improvement Protocol (TIP) Series

25

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The opinions expressed herein are the views of the Consensus Panel members and do not reflect U.S. Department of Health and Human Services (DHHS). No official support or endorsement of CSAT, SAMHSA, or DHHS for these opinions or for particular instruments or software that may be described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized patient care and treatment decisions.

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What Is a TIP?

Treatment Improvement Protocols (TIPs) are best practice guidelines for the treatment of substance abuse, provided as a service of the Substance Abuse and Mental Health Service Administration's Center for Substance Abuse Treatment (CSAT). CSAT's Office of Evaluation, Scientific Analysis, and Synthesis draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

The TIPs Editorial Advisory Board, a distinguished group of substance abuse experts and professionals in such related fields as primary care, mental health, and social services, works with the State Alcohol and Other Drug Abuse Directors to generate topics for the TIPs based on the field's current needs for information and guidance.

After selecting a topic, CSAT invites staff from pertinent Federal agencies and national organizations to a Resource Panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the TIP. Then recommendations are communicated to a Consensus Panel composed of non-Federal experts on the topic who have been nominated by their peers. This Panel participates in a series of discussions; the information and recommendations on which they reach consensus form the foundation of the TIP. The members of each Consensus Panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A Panel Chair (or Co-Chairs) ensures that the guidelines mirror the results of the group's collaboration.

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the TIP is prepared for publication, in print and online. The TIPs can be accessed via the Internet on the National Library of Medicine's home page at the URL: http://text.nlm.nih.gov. The move to electronic media also means that the TIPs can be updated more easily so they continue to provide the field with state-of-the-art information.

While each TIP strives to include an evidence base for the practices it recommends, CSAT recognizes that the field of substance abuse treatment is evolving, and research frequently lags behind the innovations pioneered in the field. A major goal of each TIP is to convey "front-line" information quickly but responsibly. For this reason, recommendations proffered in the TIP are attributed to either Panelists' clinical experience or the literature. If there is research to support a particular approach, citations are provided.

This TIP, *Substance Abuse Treatment and Domestic Violence*, presents treatment providers with an introduction to the field of domestic violence. It gives providers useful information on the role of substance abuse in domestic violence—both among the men who batter and the women who are battered. Useful techniques for detecting and eliciting such information are supplied, along with ways to modify treatment to ensure victims' safety and to stop the cycle of violence in both parties' lives. Legal issues, including duty to warn and confidentiality, are discussed. Finally, the Panel provides a blueprint for a more integrated system of care that would enhance treatment for both problems. This section includes practical suggestions for establishing linkages both between substance abuse treatment providers and domestic violence support workers and with legal, health care, criminal justice, and other relevant service agencies.

Other TIPs may be ordered by contacting The National Clearinghouse for Alcohol and Drug Information (NCADI), (800) 729-6686 or (301) 468-2600; TDD (for hearing impaired), (800) 487-4889.

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Foreword

The Treatment Improvement Protocol (TIP) series fulfills SAMHSA/CSAT's mission to improve treatment of substance use disorders by providing best practices guidance to clinicians, program administrators, and payers. TIPs are the result of careful consideration of all relevant clinical and health services research findings, demonstration experience, and implementation requirements. A panel of non-Federal clinical researchers, clinicians, program administrators, and patient advocates debates and discusses their particular area of expertise until they reach a consensus on best practices. This panel's work is then reviewed and critiqued by field reviewers.

The talent, dedication, and hard work that TIPs panelists and reviewers bring to this highly participatory process have bridged the gap between the promise of research and the needs of practicing clinicians and administrators. We are grateful to all who have joined with us to contribute to advances in the substance abuse treatment field.

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Executive Summary and Recommendations

Substance Abuse Treatment and Domestic Violence is one of the most ambitious documents in the Treatment Improvement Protocol (TIP) series. The Consensus Panel responsible for developing this TIP aimed to open a line of communication between two fields that have worked largely in isolation from each other, despite the considerable overlap in their client populations. Because both the domestic violence and substance abuse treatment fields are relatively young and new to each other, neither has yet consistently implemented programs that facilitate interagency coordination and cooperation. Basic differences in philosophy and terminology have also blocked the collaborative care that the Consensus Panel considers critical for treating substance-abusing clients who are survivors or perpetrators of violence.

This TIP primarily represents the views of domestic violence experts. Panel members combined their hard-won experience working with survivors and perpetrators of domestic violence with research literature from both disciplines to create an integrated knowledge base about substance abuse and domestic violence and to outline a system of integrated care. For some providers, implementing the collaborative model of service delivery described in the TIP may prove untenable at this time. It is the Panel's hope, however, that the suggestions presented will help providers move toward a more integrated delivery system that can provide the appropriate holistic care to their clients who suffer from both of these complex, intertwined problems.

Scope of the TIP

Domestic violence is the use of intentional verbal, psychological, or physical force by one family member (including an intimate partner) to control another. This TIP focuses only on men who abuse their female partners (batterer clients) and women who are battered by their male partners (survivor clients). Child abuse and neglect, elder abuse, women's abuse of men, and domestic violence within same-sex relationships are important issues that are not addressed in depth in this document, largely because each requires separate comprehensive review. Other patterns of domestic violence outside the scope of this TIP are abused women who in turn abuse their children or react violently to their partners' continued attacks and adult or teenage children who abuse their parents.

Researchers have found that one fourth to one half of men who commit acts of domestic violence also have substance abuse problems (Gondolf, 1995; Leonard and Jacob, 1987; Kantor and Straus, 1987; Coleman and Straus, 1983; Hamilton and Collins, 1981; Pernanen, 1976) and that a sizable percentage of convicted batterers were raised by parents who abused drugs or alcohol (Bureau of Justice Statistics, 1994). Studies also show that women who abuse alcohol and other drugs are more likely to be victims of domestic violence (Miller et al., 1989).

The primary purpose of this document is to provide the substance abuse treatment field with an overview of domestic violence so that providers can understand the particular needs and behaviors of batterers and survivors as defined above and tailor treatment plans accordingly. This requires an understanding not only of clients' issues but also of when it is necessary to seek help from domestic violence experts. The TIP also may prove useful to domestic violence support workers whose clients suffer from substance-related problems. As the TIP makes clear, each field can benefit enormously from the expertise of the other, and cooperation and sharing of knowledge will pave the way for the more coordinated system of care discussed in Chapter 6. Future publications will examine those aspects of the problem that concern such special populations as adolescent gang members, the elderly, gay men and lesbians, and women who batter. The first of these is an upcoming TIP that addresses the connections between substance abuse and child abuse and neglect.

Summary of Recommendations

Because there has been so little study of the connections between the two fields, recommendations in this TIP are largely based on the clinical experience of Consensus Panel members. Studies, mostly in the domestic violence field, are cited when appropriate.

Chapter 1 establishes the connections between substance abuse and domestic violence. While there is no direct cause-and-effect link, the use of alcohol and other drugs by either partner is a risk factor for domestic violence. The Consensus Panel concludes that failure to address domestic violence issues among substance abusers interferes with treatment effectiveness and contributes to relapse. Therefore, the Panel recommends that substance abuse treatment programs screen all clients for current and past domestic violence, including childhood physical and sexual abuse. When possible, domestic violence programs should screen clients for substance abuse. (Screening instruments and techniques for identifying domestic violence appear in Chapters 2, 3, and 4 as well as Appendix C.)

Screening, Referral, and Treatment of Survivor Clients And Batterer Clients

Chapters 2 and 3 provide an overview of, respectively, survivor clients and batterer clients, each of whom present complex treatment challenges. Chapter 4 builds on this information and discusses screening and referral in more detail. Though Chapters 2 and 3 serve primarily to introduce these populations and their specific problems, recommendations for treatment do appear in those discussions. To provide a clearer picture of the process, therefore, recommendations from Chapters 2, 3, and 4 are presented below to follow each type of client chronologically through screening, referral, and treatment.

Survivors

- If a client believes that she is in immediate danger from a batterer, the treatment provider should respond to this situation before addressing any other issues and, if necessary, should suspend the screening interview for this purpose. The provider should refer the client to a domestic violence program and possibly to a women's shelter and to legal services.
- To determine if a woman is a victim of domestic violence, look for physical injuries,

especially patterns of untreated injuries to the face, neck, throat, and breasts. Other indicators may include a history of relapse or noncompliance with substance abuse treatment plans; inconsistent explanations for injuries and evasive answers when questioned about them; complications in pregnancy (including miscarriage, premature birth, and infant illness or birth defects); stress-related illnesses and conditions (such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue); anxiety-related conditions (such as heart palpitations, hyperventilation, and panic attacks); sad, depressed affect; or talk of suicide.

- Always interview clients about domestic violence in private.
- Ask about violence using concrete examples and hypothetical situations rather than vague, conceptual questions.
- In framing screening questions, it is extremely important to convey to the survivor that there is no justification for the battering and that substance abuse is no excuse. Questions such as, "Does he blame his violence on his alcohol or drug use?" or, "Does he use alcohol (or other drugs) as an excuse for his violence?" serve the dual purpose of determining whether the client's partner may be a substance abuser while reinforcing to her that substance abuse is not the real reason for his violence.
- Though addictions counselors can be trained relatively easily to screen clients for domestic violence, once it is confirmed that a client has been or is being battered, domestic violence experts should be contacted. Violence assessment requires in-depth knowledge and skill and should be conducted by a domestic violence expert.
- Providers should be alert to the possibility that the mother of a child who has been or is being abused by her partner is also being abused herself.
- The provider should contact a forensics expert to document the physical evidence of battering.
- Once the client has entered substance abuse treatment, a treatment plan that includes a relapse prevention plan and a safety plan (see Appendix D) should be developed.
- Survivors appear to benefit by participating in same-sex treatment groups that do not use confrontational techniques.
- Survivors can be asked to sign a "no-contact contract" agreeing not to communicate with their batterers for the duration of treatment.
- Referrals should be made whenever appropriate for psychotherapy and specialized counseling. Even so, staff training in this area is important so that treatment providers can respond effectively in a crisis.
- Should a client decide to relocate to another community, she should be referred to the appropriate programs within that community.
- Because batterers in treatment frequently harass their partners by circumventing program rules and threatening them by phone, by mail, and by sending messages through other, approved visitors, telephone and visitation privileges should be carefully monitored for identified batterers and survivors in residential substance abuse treatment programs.

Batterers

- A discussion of family relationships is an element of all substance abuse screening interviews. Use this component of the interview to address the issue of domestic violence with male clients.
- To initially gauge the possibility that a client is being abusive toward his family members, the interviewer can ask whether he thinks

violence against a partner is justified in some situations, using a third person example.

- Ask specific, concrete questions (e.g., "What happens when you lose your temper?").
- Define violence (e.g., "When you hit her, was it a slap or a punch?", "Do you take her car keys away?", "Damage her property?", "Threaten to hurt or kill her?").
- Once it has been confirmed that a client is a batterer, the provider should contact a domestic violence expert, either for referral or consultation. Treatment providers should collaborate with a batterers' program to ensure that an assessment of dangerousness is performed.
- Be direct and candid; avoid euphemisms such as, "Is your relationship with your partner troubled?" Instead, talk about "his violence" and keep the focus on "his behavior."
- Become familiar with batterers' excuses for their behavior:
  - *Minimizing*: "I only pushed her," "She bruises easily," "She exaggerates."
  - *Citing good intentions*: "She gets hysterical so I have to slap her to calm her down."
  - *Use of alcohol and drugs*: "I'm not myself when I drink."
  - *Claiming loss of control*: "Something snapped," "I can only take so much," "I was so angry, I didn't know what I was doing."
  - *Blaming the partner*: "She drove me to it," "She really knows how to get to me."
  - *Blaming someone or something else*: "I was raised that way," "My probation officer is putting a lot of pressure on me," "I've been out of work."
- In asking screening questions, substance abuse treatment providers must be careful not to enable a batterer to place the blame for the battering on the victim or the drug.
- Domestic violence staff sometimes interview the batterer's partner in order to obtain salient information about his dangerousness to himself, his partner, and others. This type of collateral interviewing is quite different from that practiced in the substance abuse treatment setting and should only be performed by someone with *specialized skills and expertise in domestic violence*.
- Treatment providers should try to ensure the safety of those who have been or may become a perpetrator client's victims, in particular his partner and children, during any crisis that precedes or occurs during the course of his treatment.
- Treatment providers should mandate that batterers in treatment sign a "no-violence contract" that states that the client will, among other stipulations, refrain from using violence both inside and outside the program.
- Treatment providers should elicit the following information about the relationship between the substance abuse and the violent behavior:
  - Exactly when in relation to substance abuse the violence occurs
  - How much of the violent behavior occurs while the batterer is drinking or on other drugs
  - What substances are used before the violent act
  - What feelings precede and accompany the use of alcohol or other drugs
  - Whether alcohol or other drugs are used to "recover" from the violent incident.
- After identifying the chain of events that precede or trigger violent episodes, provider and client should together formulate strategies for modifying those behaviors and recognizing emotions that contribute to violent behavior.
- Providers should be alert to signs that batterer clients are misinterpreting the 12-Step philosophy to justify or excuse continued violence. Another danger is that

they will call their victims "codependent" in order to shift blame for the battering onto the woman.

- Referrals to self-help aftercare groups like Batterers Anonymous (BA) groups should be made only after the client has completed a batterers' intervention program and has remained nonviolent for a specified period of time.

Screening for Child Abuse

- During the initial screening of a client, the Consensus Panel recommends that the interviewer should attempt to determine whether the client's children have been physically harmed and whether their behavior has changed (e.g., they have become mute or they scream or cry).
- Inquiries into possible child abuse should not occur until notice of the limitations of confidentiality as defined in Title 42, Part 2, of the *Code of Federal Regulations* has been given and the client has acknowledged receipt of it in writing. Clients also must be informed that mandated reporters, a category that includes substance abuse treatment providers, are required to notify a children's protective services (CPS) agency if they suspect child abuse or neglect.
- The substance abuse treatment provider should not perform an assessment of children for abuse or incest; this function should be performed by personnel with special expertise. The treatment provider should, however, note any indications of whether abuse of children is occurring in a client's household and pass on what he or she finds to the appropriate agency. Indications of child abuse that can be gleaned in a client interview include:
  - Whether CPS has been involved with anyone who lives in the home
  - Children's behaviors such as bedwetting and sexual acting out
  - "Special" closeness between a child and other adults in the household
  - The occurrence of "blackouts": Batterers often claim blackouts for the period of time during which violence occurs.
- If a treatment provider suspects that the child of a client has been a victim of violence, he or she must refer the child to a health care provider immediately. If it appears that the parent will not take the child to a doctor (who is required by law to report the suspected abuse), the provider must contact home health services or CPS.
- The treatment provider must assess the impact on a survivor client of reporting suspected or confirmed child abuse or neglect and develop a safety plan if necessary.

Legal Issues

Chapter 5 discusses the Federal, State, and local regulations that bear upon domestic violence, particularly the 1994 Violence Against Women Act (VAWA). Also covered are issues such as restraining orders, duty to warn, the legal obligation to report threats and past crimes, and confidentiality.

- Substance abuse treatment providers should be familiar with relevant Federal, State, and local regulations as well as with the legal resources available to victims of domestic abuse.
- Treatment providers must fulfill their legal obligation to report domestic violence and suspected child abuse and neglect.
- Treatment providers should never discuss their clients with lawyers, law enforcement officers, or anyone else without the client's permission. Only certain types of subpoenas and warrants (discussed in Chapter 5) require that records be turned over.

- Treatment providers should coordinate their efforts with domestic violence workers to ensure that clients avoid problems under the provisions of "welfare reform" (The Personal Responsibility and Work Opportunity Reconciliation Act of 1996).

Establishing Linkages

Chapter 6 recommends linkages between substance abuse treatment programs and domestic violence programs and among other agencies as well. A model for systemic reform is provided in addition to suggestions for implementing community-based systems of coordinated care.

Systemic reform

- Treatment providers and domestic violence support workers should foster a new way of thinking about linkages on the systems level. Both fields would benefit from a coordinated system that could address the multiple social service needs of substance-abusing victims and perpetrators of violence.
- A new mechanism should be developed at the State level to coordinate planning among disparate agencies based on client needs assessments; devise financing strategies that would allow for blended funding and strive for equitable allocation of resources among agencies; and establish a vehicle for resolving any problems that emerge in the course of providing integrated services.
- Linkages should address needs for housing, child care, emotional and physical safety, health and mental health care, economic stability, legal protection, vocational and educational services, parenting training, and support and peer counseling, among others.
- The services provided should be holistic, flexible, collaborative, coordinated, and accountable.
- Linkages should address needs for housing, child care, emotional and physical safety, health and mental health care, economic stability, legal protection, vocational and educational services, parenting training, and support and peer counseling, among others.
- Federal and State policymakers should consider a series of demonstrations designed to test the feasibility of changing the current system to institutionalize a formal administrative structure for promoting and supporting collaboration and linkages among social service programs.

Community linkages

- In the absence of systemic reform, substance abuse treatment providers, domestic violence experts, and legal or other relevant professionals should plan treatment collaboratively.
- A legal professional or legal service is the best resource for resolving problems that pertain to individual clients' involvement in the justice system and may be the best resource for information and guidance regarding VAWA.
- Initial meetings between organizations trying to establish linkages should include discussion of the origins of both communities in order to help each understand the other's beliefs and attitudes.
- The choice of outcomes to measure must be made carefully: The definition of success must be palatable to funders and third party payers as well as experts in the field.
- Credentialing processes for substance abuse treatment providers should assess their ability to screen for violence and create a safety plan, as well as their knowledge of legal issues related to domestic violence.

Supplemental Materials

The TIP also includes resources to help providers implement the recommendations in the TIP. Appendix B explores how the Federal confidentiality regulations affect treatment decisions for batterer and survivor clients. Appendix C is a collection of instruments to screen for domestic violence and to assess a batterer's dangerousness. Appendix D reproduces a safety plan that a provider can use with survivor clients, and Appendix E lists national programs and hotlines concerning domestic violence.

1 Effects of Domestic Violence on Substance Abuse Treatment

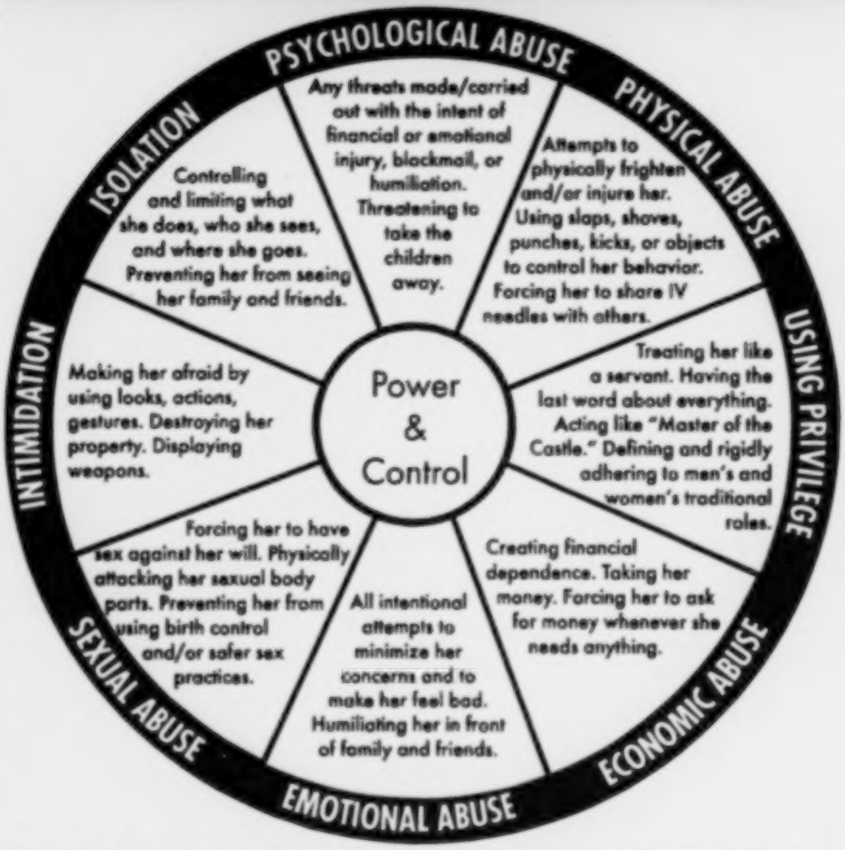
Domestic violence is the use of intentional emotional, psychological, sexual, or physical force by one family member or intimate partner to control another. Violent acts include verbal, emotional, and physical intimidation; destruction of the victim's possessions; maiming or killing pets; threats; forced sex; and slapping, punching, kicking, choking, burning, stabbing, shooting, and killing victims. Spouses, parents, stepparents, children, siblings, elderly relatives, and intimate partners may all be targets of domestic violence (Peace at Home, 1995). (See Figure 1-1.)

This Treatment Improvement Protocol (TIP) focuses on heterosexual men who abuse their domestic partners and on women who are abused by men, because these individuals constitute a significant portion of the population seeking substance abuse treatment. Though domestic violence encompasses the range of behaviors above, the TIP focuses more on physical, or a combination of physical, sexual, and emotional, violence. Therefore men who abuse their partners are referred to throughout as *batterers*; women who are abused are called *survivors*. Child abuse and neglect, elder abuse, women's abuse of men, and domestic violence within same-sex relationships are important issues that are not addressed in depth in this document, largely because each requires separate comprehensive review. Other patterns of domestic violence outside the scope of this TIP are abused women who in turn abuse their children or react violently to their partners' continued attacks and adult or teenage children who abuse their parents.

The primary purpose of this document is to provide the substance abuse treatment field with an overview of domestic violence so that providers can understand the particular needs and behaviors of batterers and survivors as defined above and tailor treatment plans accordingly. This requires an understanding not only of clients' issues but also of when it is necessary to seek help from domestic violence experts. The TIP also may prove useful to domestic violence support workers whose clients suffer from substance-related problems.

As the TIP makes clear, each field can benefit enormously from the expertise of the other, and cooperation and sharing of knowledge will pave the way for the more coordinated system of care discussed in Chapter 6. Future publications will examine aspects of the problem that concern such special populations as adolescent gang members, the elderly, gay men and lesbians, and women who batter. The first of these is an upcoming TIP that addresses substance abuse by victims of child abuse and neglect.

Figure 1-1
Manifestations of Domestic Violence


PSYCHOLOGICAL ABUSE
Any threats made/carried out with the intent of financial or emotional injury, blackmail, or humiliation. Threatening to take the children away.
PHYSICAL ABUSE
Attempts to physically frighten and/or injure her. Using slaps, shoves, punches, kicks, or objects to control her behavior. Forcing her to share IV needles with others.
USING PRIVILEGE
Treating her like a servant. Having the last word about everything. Acting like "Master of the Castle." Defining and rigidly adhering to men's and women's traditional roles.
ECONOMIC ABUSE
Creating financial dependence. Taking her money. Forcing her to ask for money whenever she needs anything.
EMOTIONAL ABUSE
All intentional attempts to minimize her concerns and to make her feel bad. Humiliating her in front of family and friends.
SEXUAL ABUSE
Forcing her to have sex against her will. Physically attacking her sexual body parts. Preventing her from using birth control and/or safer sex practices.
INTIMIDATION
Making her afraid by using looks, actions, gestures. Destroying her property. Displaying weapons.
ISOLATION
Controlling and limiting what she does, who she sees, and where she goes. Preventing her from seeing her family and friends.
Power & Control

Source: Casa Myrna Vazquez, Inc. Adapted from the Domestic Abuse Intervention Project by Elba Crespo-Gonzalez. Developed for Casa Myrna Vazquez, Inc., and sponsored by the Boston Health Start Initiative, 1993.

Defining the Problem

In the United States, a woman is beaten every 15 seconds (Dutton, 1992; Gelles and Straus, 1988). At least 30 percent of female trauma patients (excluding traffic accident victims) have been victims of domestic violence (McLeer and Anwar, 1989), and medical costs associated with injuries done to women by their partners total more than $44 million annually (McLeer and Anwar, 1987). Much like patterns of substance abuse, violence between intimate partners tends to escalate in frequency and severity over time (Bennett, 1995). "Severe physical assaults of women occur in 8 percent to 13 percent of all marriages; in two-thirds of these relationships, the assaults reoccur (Dutton, 1988)" (Bennett, 1995, p. 760). In 1992, an estimated 1,414 females were killed by "intimates," a finding that underscores the importance of identifying and intervening in domestic violence situations as early as possible (Bureau of Justice Statistics, 1995).

An estimated three million children witness acts of violence against their mothers every year, and many come to believe that violent behavior is an acceptable way to express anger, frustration, or a will to control. Some researchers believe, in fact, that "violence in the family of origin [is] consistently correlated with abuse or victimization as an adult" (Bennett, 1995, p. 765; Hamberger and Hastings, 1986a; Kroll et al., 1985). Other researchers, however, dispute this claim. The rate at which violence is transmitted across generations in the general population has been estimated at 30 percent (Kaufman and Zigler, 1993) and at 40 percent (Egeland et al., 1988). Although these figures represent probabilities, not absolutes, and are open to considerable interpretation, they suggest to some that 3 or 4 of every 10 children who observe or experience violence in their families are at increased risk for becoming involved in a violent relationship in adulthood.

Identifying the Connections

Researchers have found that one fourth to one half of men who commit acts of domestic violence also have substance abuse problems (Gondolf, 1995; Leonard and Jacob, 1987; Kantor and Straus, 1987; Coleman and Straus, 1983; Hamilton and Collins, 1981; Pernanen, 1976). A recent survey of public child welfare agencies conducted by the National Committee to Prevent Child Abuse found that as many as 80 percent of child abuse cases are associated with the use of alcohol and other drugs (McCurdy and Daro, 1994), and the link between child abuse and other forms of domestic violence is well established. Research also indicates that women who abuse alcohol and other drugs are more likely to become victims of domestic violence (Miller et al., 1989) and that victims of domestic violence are more likely to receive prescriptions for and become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol (Stark and Flitcraft, 1988a). Other evidence of the connection between substance abuse and family violence includes the following data:

- About 40 percent of children from violent homes believe that their fathers had a drinking problem and that they were more abusive when drinking (Roy, 1988).
- Childhood physical abuse is associated with later substance abuse by youth (Dembo et al., 1987).
- Fifty percent of batterers are believed to have had "addiction" problems (Faller, 1988).
- Substance abuse by one parent increases the likelihood that the substance-abusing parent will be unable to protect children if the other parent is violent (Reed, 1991).
- A study conducted by the Department of Justice of murder in families found that more than half of defendants accused of murdering their spouses—as well as almost half of the victims—had been drinking alcohol at the time of the incident (Bureau of Justice Statistics, 1994).
- Teachers have reported a need for protective services three times more often for children who are being raised by someone with an addiction than for other children (Hayes and Emshoff, 1993).
- Alcoholic women are more likely to report a history of childhood physical and emotional abuse than are nonalcoholic women (Covington and Kohen, 1984; Miller et al., 1993; Rohsenow et al., 1988; Hein and Scheier, 1996).
- Women in recovery are likely to have a history of violent trauma and are at high risk of being diagnosed with posttraumatic stress disorder (Fullilove et al., 1993).

The Societal Context

Clearly, substance abuse is associated with domestic violence, but it is not the only factor. As discussed above, witnessing or experiencing family violence during childhood is a risk factor as is a history of childhood aggression. Another factor that must be acknowledged is societal norms that indirectly excuse violence against women (tacit support for punishing unfaithful wives, for example, or stereotyped views of women as obedient or compliant) (Kantor and Straus, 1987; Reed, 1991; Bennett, 1995; Flanzer, 1990).

The overt or covert sexism that contributes to domestic violence also bears on connections between violence and substance abuse. Manifestations of that sexism vary across social classes and cultural groups: Some groups more than others accept domestic violence or intoxication as a way of dealing with frustration or venting anger. Though they range from subtle to blatant, sexist assumptions persist and are reflected by society's different responses to domestic violence and substance abuse among men and among women.

For example, substance abuse treatment providers have observed that society tolerates a man's use of alcohol and other drugs more readily than a woman's. They note that batterers often blame a woman they have victimized for the violence, either implicitly or explicitly, and other people, including police, judges, and juries, often accept this argument. Research suggests that intoxicated victims are more likely to be blamed than sober victims and that aggression toward an inebriated victim is considered more acceptable than aggression toward a sober one (Aramburu and Leigh, 1991). At least one other research team (Downs et al., 1993) argues that sexist attitudes may in fact contribute to the alcoholism of some women. "The alcoholic woman," they write, "may internalize previous negative stigmatization and subsequently use alcohol to cope with negative feelings resulting from the stigma. Conversely, the partner may use the woman's drinking as a rationale to label her negatively" (p. 131).

Attitudes toward rape are another example of how this rationalization works. Even when alcohol or other drugs are not involved, women victims frequently are assumed to have provoked their rapists by the way they behaved or dressed. This widely accepted misperception is often internalized and accounts for the guilt and shame that many rape victims experience. Not surprisingly, some victims of rape and other violence report using alcohol and other drugs to "self-medicate" or anesthetize themselves to the pain of their situations.

The Connection Between Substance Abuse and Domestic Violence

Though experts agree there is a connection between the two behaviors, its precise nature remains unclear. One researcher writes, "Probably the largest contributing factor to domestic violence is alcohol. All major theorists point to the excessive use of alcohol as a key element in the dynamics of wife beating. However, it is not clear whether a man is violent because he is drunk or whether he drinks to reduce his inhibitions against his violent behavior" (Labell, 1979, p. 264).

Another expert (Bennett, 1995) observes that

> [I]f substance abuse affects woman abuse, it does so either directly by disinhibiting normal sanctions against violence or by effecting changes in thinking, physiology, emotion, motivation to reduce tension, or motivation to increase interpersonal power (Graham, 1980). Despite its popularity, the disinhibition model of alcohol aggression is often discredited because of experiments that have found expectation of intoxication a better predictor of aggression than intoxication itself (Lang et al., 1975).
>
> An alternative to disinhibition, is 'learned disinhibition,' or expectancy of a drug and violence relationship ... Drug and alcohol use occur in a cultural context in which behavior

> can be attributed to 'I was loaded' (MacAndrew and Edgerton, 1969). (p. 761)

Within this theoretical framework, the societal view of substance abusers as morally weak and controlled by alcohol or other drugs actually serves some batterers: Rather than taking responsibility for their actions, they can blame their violent acts on the substance(s) they are abusing. Although drugs or alcohol may indeed be a trigger for violence, the belief that the violence will stop once the drinking or drug use stops is usually not borne out. The use of alcohol or other drugs may increase the likelihood that a batterer will commit an act of domestic violence—because it reduces inhibitions and distorts perceptions, because alcohol is often used as an excuse for violence, and because both alcohol abuse and domestic violence tend to follow parallel escalating patterns—but it does not fully explain the behavior (Pernanen, 1991; Leonard and Jacob, 1987; Steele and Josephs, 1990). The fact remains that nondrinking men also attack their partners, and for some individuals, alcohol actually inhibits violent behavior (Coleman and Straus, 1983).

Batterers—like survivors—often turn to substances of abuse for their numbing effects. Batterers who are survivors of childhood abuse also frequently say that they use drugs and alcohol to block the pain and to avoid confronting that memory. It is a self-perpetuating cycle: Panel members report that batterers say they feel free from their guilt and others' disapproval when they are high.

The Impact of Violence on Substance Abuse Treatment

Though it cannot be said that substance abuse "causes" domestic violence, the fact remains that substance abuse treatment programs see substantial numbers of batterers and victims among their patient populations and increasingly are compelled to deal with issues related to abuse (Flanzer, 1993).

As substance abuse treatment programs have grown more sophisticated, the treatment offered patients has become more comprehensive and more effective. Questions about vocational, educational, and housing status; coexisting mental disorders; and presence of human immunodeficiency virus (HIV) and other infectious diseases are routinely raised during the assessment process. Treatment providers now recognize the importance of addressing issues that affect clients' patterns of substance abuse (and vice versa) so that these issues do not undermine their recovery. Today, mounting evidence about the varied associations between domestic violence and substance abuse attests to the need to add violent behavior and victimization to the list of problems that should be explored and addressed during treatment. Based on their clinical experience, members of the Consensus Panel who developed this TIP conclude that failure to address domestic violence issues interferes with treatment effectiveness and contributes to relapse.

Practitioners in both fields must be attuned to the connections between the two problems. By sharing knowledge, substance abuse treatment providers and domestic violence workers can understand the complexity of the problem, address their own misperceptions and prejudices, and better serve individual clients—as well as lay the foundation for a coordinated community response. Building bridges between the fields requires an understanding of the way each problem can interfere with the resolution of the other and of the barriers posed by the two fields' differing program priorities, terminology, and philosophy.

Barriers To Addressing Domestic Violence in the Treatment Setting

Battering, victimization, and treatment effectiveness

Battering and victimization undermine substance abuse treatment in both direct and indirect ways. Consensus Panel members report that a substance-abusing woman often finds that her abusive partner becomes angry or threatened when she seeks help, and his violence or threats of violence may push her to drop out of treatment. Panel members have also seen a violent partner sabotage a woman's treatment by appearing at the program and threatening physical harm unless she leaves with him or by bullying or manipulating her to use alcohol or other drugs with him. Another variation on this theme occurs when a woman manages to continue in treatment, a violent episode occurs, and, as part of "making up," is persuaded to take alcohol or other drugs. Although these patterns occur in nonviolent relationships as well, the threats of physical harm, withholding of financial support, or abuse directed toward children can lead survivors to resort to using substances to buffer their distress. For this reason, recovery from a substance use disorder may not be possible unless client survivors improve their self-esteem, sense of competence, and ability to make sound decisions. Survivors must get to the point where they can recognize and take advantage of their options and alternatives before they can replace their substance use with positive coping strategies.

When batterers enter treatment, their partners also may subvert their efforts to achieve sobriety. Some batterers are less violent and easier to handle when they are drunk or high. If a batterer is more violent when sober or abstinent, his partner may encourage drinking or taking drugs. "Enabling" is actually a safety measure in these cases. Another complicating factor is some women's perception that they are responsible for their partners' substance abuse, a perception that often is reinforced by their partners, friends, and family. In the same way that they hold themselves culpable for their battering, those women believe that their "bad" behavior prompts their partners' use of alcohol or other drugs, a position that abusers exploit to rationalize their continued substance abuse.

Program priorities, terminology, and philosophy

The problems of substance abuse and domestic violence intersect in destructive ways; furthermore, differences in priorities, terminology, and philosophy have hampered collaboration between providers in the two fields. For substance abuse, attaining abstinence is a key goal; for domestic violence programs, ensuring survivors' safety is of paramount concern. While both goals are valid, the reality is that they may be difficult to balance. The problem for substance abuse and domestic violence staff then lies in the perception that one goal invariably must be selected to the exclusion of the other for a program to preserve its identity and thereby carry out its mission.

A heightened awareness of the two problems, however, reveals that programs can forego an "either/or approach," shift priorities to accommodate a client's situation, and still retain program identity and orientation. A female substance abuser's living arrangements, for example, may be so dangerous that regular attendance at treatment will be impossible until safety issues are resolved. In this case, substance abuse treatment could be temporarily postponed and then reinitiated after a more secure environment can be achieved. Conversely, some survivors remain in traumatic relationships because of their addiction. Their batterer is their supplier, and they endure the intolerable in order to feed their habit. Delaying development of a safety plan until the drug problem is addressed could be a more effective strategy under those circumstances. Adjusting priorities on a case-by-case basis does not undermine a particular program's philosophy; instead it recognizes the need for flexibility in responding to individual client needs.

Differences in terminology pose another potential barrier to effective networking. Domestic violence programs try to avoid negative language by using such positive terms as *empowerment* to encourage battered women to move forward and build a new life. *Denial, enabling, codependency,* and *powerlessness*—terms widely used in the substance abuse field to describe typical client behaviors and aspects of recovery—strike some domestic violence workers as stigmatizing, repressive, and counter to appropriate goals for violence survivors.

Increasingly, substance abuse is considered a brain disorder that deserves treatment in much the same way as hypertension and diabetes do. In contrast, domestic violence counselors tend to distance themselves from medical models that imply that survivors are "sick" when, in fact, they have been battered by someone else. To forestall divisions between the two fields, etiological differences must not only be recognized, but accepted as legitimate.

Other features of substance abuse treatment that have posed problems for domestic violence programs and have inhibited collaboration between the two fields are the largely male clientele, the emphasis on family involvement, and the use of confrontational group therapy. Some domestic violence professionals worry that the male orientation in many substance abuse treatment programs makes these programs irrelevant to the realities of women's lives, insensitive to their needs, and inapplicable to the issue of domestic violence. They also believe that enlisting the help of family members and significant others in the treatment process can, in the case of violent partners, endanger the survivor. Likewise, domestic violence professionals who work with survivors consider the confrontational techniques used by some substance abuse treatment providers to overcome denial and resistance to treatment as "bullying" and inappropriate.

Although there is some validity to these characterizations (as well as to the claim that domestic violence staff are uninformed and naive about substance abusers and the manipulative behaviors they sometimes employ), education, communication, and cross-training can help to overcome barriers between substance treatment and domestic violence programs. Increased understanding within both disciplines will equip practitioners to address the particular problems of substance abusers who are victims or perpetrators of domestic violence.

A New Way of Thinking

The disagreements between experts in the fields of substance abuse and domestic violence can inhibit the exchange of essential information to the detriment of the client's recovery. This TIP represents an initial effort to bridge that gap. In the chapters that follow, experts in the respective arenas share their understanding about the impact of domestic violence on batterers and survivors. In addition, this TIP provides suggestions for screening and assessing for past and current experience with domestic violence, offers ideas for intervening with survivor and perpetrator clients, and summarizes legal and ethical issues that substance abuse providers should consider when working with this population. In addition to presenting guidelines to improve client outcomes, the information included in this document is intended to begin a dialogue between domestic violence and substance abuse treatment staff about the larger issue of systemic reform. Currently, domestic violence and substance abuse treatment function as parallel programs within the overall social services system.

In the short term, the ideas presented in this TIP should enhance the responses of both programs to the problems of domestic violence survivors and batterers who are also substance abusers. However, to effect lasting change and reduce morbidity, people working in both fields must accept the fact that the two problems often exist together, must recognize the importance of a holistic treatment approach, must be willing to set aside concerns about "turf," and must learn to collaborate effectively on the client's behalf. Impediments to systemic reform are scattered throughout substance abuse and domestic violence programs and in the public and private funding organizations supporting them. The insistence on identifying a single problem as primary or the need to conceal a problem in order to receive services can complicate admission to treatment, interfere with the development of appropriate treatment plans, and ultimately derail progress. In the concluding chapter of this TIP, Chapter 6, the Panel offers ideas for forging systemwide linkages that exemplify a new, collaborative way of thinking about problems and their solutions. This chapter builds on the practical suggestions described in earlier chapters to create a blueprint for a system of coordinated care. Such a unified system would be better equipped than the current fragmented one to interrupt the cycle of violence, fear, intimidation, guilt, and relapse to substance abuse that jeopardizes clients' recovery.

2 Survivors of Domestic Violence: An Overview

This chapter presents an overview of those issues likely to affect survivors of domestic violence seeking treatment for substance abuse. Its purpose is to help substance abuse treatment providers understand the impact of this experience on the treatment and recovery process and appreciate the differences in approach between the fields of substance abuse and domestic violence as they affect the survivor, so that treatment programs can respond more appropriately to this client group. The primary focus of substance abuse treatment services is to initiate the recovery process and reinforce the skills needed to stay sober or abstinent, while domestic violence programs seek to interrupt the cycle of violence and help the survivor client access the information and resources she needs to increase her safety and to develop and implement a safety plan. Holistic care is impossible if a treatment provider cannot understand the profound effect of domestic violence on a survivor.

The battered woman lives in a war zone: She rarely knows what will trigger an abusive episode, and often there is little, if any, warning of its approach. She spends a great deal of time and energy trying to read subtle signs and cues in her partner's behavior and moods in order to avoid potential violence, but she is not always successful. Financial constraints and fear that the batterer will act on his threats to harm family members or continually harass, stalk, and possibly kill her often inhibit victims from leaving (Rodriguez et al., 1996). If the batterer is also the victim's drug supplier, that further complicates the situation. Assuming all these issues can be resolved, the effects of continual abuse and verbal degradation can be so inherently damaging to self-esteem that the survivor may believe that she is incapable of "making it" on her own.

Entering the Treatment System

Crisis Intervention

When a client presents for substance abuse treatment and informs staff that she is a victim of domestic violence, treatment providers should focus on

1. *Ensuring her safety:* Whether a client is entering inpatient or outpatient treatment, the immediate physical safety of her environment must be the chief concern. If inpatient, security measures should be intensified; if outpatient, a safety plan (which may include immediate referral to a domestic violence or battered women's shelter) should be developed. In both cases, staff should be cautioned about the importance of vigilantly guarding against breaches in confidentiality.

2. *Validating and believing her, and assuring her that she is believed:* Reinforcement of the counselor's belief of a survivor's victimization is a critical component of ongoing emotional support. Affirming the survivor's experience helps empower her to participate in immediate problem solving and longer term treatment planning.
3. *Identifying her options:* Treatment providers should ask the survivor to identify her options, share information that would expand her set of available options, explore with her the risks associated with each option, and support her in devising a safety plan.

These three goals remain important for a survivor throughout treatment. Other needs that must be addressed immediately are

- Stabilizing detoxification (including withdrawal symptoms, if any).
- Evaluating and treating any health concerns, including pregnancy. The latter is especially important for a survivor client because batterers often intensify their abuse when they learn their partner is pregnant (Hayes and Emshoff, 1993; Stark et al., 1981). Injuries should be documented for any future legal proceedings that might occur.
- Attending to immediate emotional and psychological symptoms that may interfere with the initiation of treatment, such as acute anxiety and depression.

Once survivor clients' physical safety and symptoms have been addressed, treatment providers can obtain the information necessary to design a treatment plan.

Obtaining a History

A number of issues unique to domestic violence survivors must be considered by substance abuse treatment providers who work with these clients. Chief among these is the need to uncover the extent of the client's history of domestic violence. The survivor client's current substance abuse problems must be placed in the context of whatever violence and abuse she may have experienced throughout her life, both within her current family and in her family of origin. Childhood sexual abuse has been associated with a higher risk for "revictimization" later in life (Browne and Finkelhor, 1986). (See Chapter 4 for a discussion on how to elicit information regarding domestic violence.)

Studies have found a higher incidence of substance abuse among women who were victims of childhood sexual abuse and sexual assault (Ryan and Popour, 1983; Reed, 1985). Data suggest that substance abuse often begins at an early age and may become part of a self-destructive coping style that is sometimes seen in incest victims (Harrison et al., 1989; Conte and Berliner, 1988; Briere, 1989). It is not unusual for the abuser to foster the child's initiation into alcohol and drugs in order to make the child more compliant.

A discussion of substance abuse in the client's history should cover her current use, her treatment history, and alcohol or other drug use in her family of origin. In addition, patterns and frequency of alcohol or other drug use by her batterer are key to understanding the relationship of substance abuse to the violence.

Substance abuse counselors should be aware that survivors often are reluctant to disclose the extent of violence in their lives. Often a survivor's denial that violence occurs is so pervasive that it has become an integral element of her psyche. And, especially if violence existed in her family of origin, she may simply consider it a normal part of an intimate relationship.

At the same time, it is important to recognize that many survivors consciously keep the fact or extent of their battering concealed for good reasons, such as fear for themselves, their children, or other family members. When a battered woman leaves her abuser, her chances of being killed increase significantly (Wilson, 1989; Casanave and Zahn, 1986; Rasche, 1993; Dutton-Douglas and Dionne, 1991). Furthermore, the batterer may be the primary source of income, so his incarceration could leave her destitute (Rodriguez et al., 1996). Instruments for uncovering domestic violence appear in Appendix C.

Treatment Planning for The Survivor Client

Treatment providers can best serve clients by establishing strong linkages to domestic violence referral and intervention services and by employing staff who are thoroughly familiar with local and State laws regarding domestic violence and with the unique needs of the domestic violence survivors. Ideally, counselors should be able to refer to those services and staff members when domestic violence is suspected and call on them for consultation as needed. If a client denies a history of domestic abuse but the treatment provider still suspects it is possible, additional attempts to discuss it with the client should be made and documented. Once the client has entered treatment, a treatment plan that includes guarantees of safety (see Appendix D) and a relapse prevention plan should be developed. Considerations specific to domestic violence survivors should be integrated into each phase of the treatment plan.

Safety From the Batterer

In the early stages of the survivor's treatment, the substance abuse counselor should help her develop a long-term safety plan either by referring the client to or employing domestic violence service providers. If substance abuse counselors have been well trained in this area, they can work with clients to develop such a plan as part of intake.

One of the purposes of screening is to assess the degree to which the survivor is in physical danger. Screening for this purpose should be conducted early in the treatment process. However, domestic violence and safety issues do not always arise in the early stages of treatment of these clients. Thus substance abuse treatment providers are wise to be prepared to develop a safety plan whenever the need becomes known or acknowledged. (See Chapter 4 on screening and assessment for a discussion on assessing danger and lethality and Appendix C for an example of a danger assessment instrument). In this regard, it is also important to remember that the client's sobriety may threaten the batterer's sense of control. In response, he may attempt to sabotage her recovery or increase the violence and threats in order to reestablish control. It is important to address this issue in treatment and to help the client minimize her risk of harm so that she can continue to comply with her treatment plan. In addition, although involving the family in counseling is usually a precept of successful substance abuse treatment, couples and family therapy may be dangerous for domestic violence survivors and should be undertaken cautiously, if at all.

It is also important for the substance abuse provider to assess the degree to which an addicted client's drug problem is tied to the abusive partner: Her batterer may be her supplier. A survivor client who relies on a batterer to obtain or administer drugs may have a difficult time remaining in treatment or avoiding the batterer. A batterer who understands his partner's addiction may simply wait for the victim to resurface. The treatment provider should be alert to the possibility that a survivor client may sabotage both her treatment and her safety in the service of her addiction.

Physical Health

Domestic violence survivors often present with acute injuries and long-term sequelae of battering as well as the physical health problems more commonly associated with substance abuse (e.g., skin abscesses and hepatitis). Cuts and bruises from domestic violence tend to be on the face, head, neck, breasts, and abdomen (Randall, 1990). The body map in the Abuse Assessment Screen (see Appendix C) can help identify these injuries. Abdominal pain, sleeping and eating disorders, recurrent vaginal infections, and chronic headaches are also common among survivors (American Medical Association, 1992; Beebe, 1991; Stark et al., 1981; Randall, 1990). While it may be necessary to attend to pressing legal and financial concerns before chronic health problems can be addressed, medical staff should be available to assess the client's most immediate physical, emotional, and mental health needs.

When a woman presents for treatment with obvious signs of or complaints about physical battering or sexual abuse, staff should consider enlisting a forensic expert to help the survivor client obtain proper medical documentation of her injuries. Forensic medicine programs have been employed successfully in pediatric populations (Corey Handy et al., 1996), and are now being expanded to include adult victims of abuse. Forensic examiners are medicolegal experts (e.g., nurses, emergency room physicians, and forensic pathologists) specially trained to evaluate, document, and interpret injuries for legal purposes (Corey Handy et al., 1995). They can assess whether an injury is consistent with events as described by the victim or perpetrator client, information especially valuable when the victim is unable to accurately recount the circumstances surrounding her injuries because she was using alcohol or other drugs at the time of the assault. Forensic examiners frequently are called to testify in court and may be viewed as a valuable asset in any court proceeding relating to the assault (Corey Handy et al., 1995).

Other health concerns that need attention early in treatment include screening and care for pregnancy, HIV infection, and other sexually transmitted diseases (STDs). Battered women are at extraordinarily high risk for STDs because they are frequently unable to negotiate the practice of safe sex with their partners and are often subjected to forced, unprotected sex. They also may have been forced by their partners to share needles. Not only do STDs and pregnancy require immediate medical attention, but they can also be triggers for more battering.

One of the coping mechanisms used by many survivors is the repression of physical sensations, including physical pain. Often the survivor's awareness of physical pain and discomfort resurfaces only when the traumatic effects of the abuse have been relieved. An increase in a client's somatic symptoms is also common as emotional issues surrounding her victimization begin to emerge. Such a newfound awareness can be confusing and frightening for the survivor, and it is important to ensure that this awareness is addressed both in her medical care and through psychotherapeutic counseling.

Psychosocial Issues

Shift of focus and responsibility to the abuser

A key aspect of treatment for substance abuse is encouraging the client to assume responsibility for her addiction. For a survivor client, it is critical at the same time to dispel the notion that she is responsible for her partner's behavior. *She is only responsible for her own behavior.*

The survivor client must realize that she does not and cannot control her partner's behavior, no matter what he says. Treatment should help move her toward becoming an autonomous individual who is not at the mercy of external circumstances. Concrete steps to ensure her safety or, if she decides to leave the batterer, to set up a new life will do more toward this end than anything else. As she frees herself from the violence, she will feel more independent. A counselor can help reinforce the client's view of herself as capable and competent by eliciting information about her efforts to address the violence, even if they were unsuccessful. A counselor can point out that her efforts reflect determination, creativity, resourcefulness, and resilience, many of the same qualities that will equip her to take responsibility for her substance abuse.

Improving decisionmaking skills

Poorly developed decisionmaking skills is a problem for many substance abusers. When a client is a battered woman, that inadequacy may be compounded by the domestic abuse (American Medical Association, 1993). For some battered women, every aspect of their lives has been controlled by the batterer, and a "wrong" decision (as perceived by the batterer) may have served as another excuse to batter her. The paralyzing effect of being battered for making independent decisions must be overcome as the survivor begins to exercise choices without fear of reprisal. Thus one of the first steps in the process of empowering the survivor client is to help her develop, strengthen, focus, or validate her decisionmaking skills.

For a proportion of domestic violence survivors, decisionmaking is a new skill that must be acquired for the first time rather than a lost skill that must be relearned. Exploring her own wants, needs, and feelings, although an unfamiliar and sometimes uncomfortable process, can be a stepping stone to making larger and longer term decisions. It is important for the treatment provider to avoid underestimating the importance to the survivor of making even seemingly mundane decisions, such as what to wear or when to eat.

Like most substance abusers, the survivor client must examine those areas of her life that will either support or undermine her recovery. Like others in treatment, she must disengage from drug-using friends, and she will need support as she begins the task of making new social contacts who support her recovery.

Reevaluating relationships with partners who support and encourage drinking or drug-taking is another therapeutic task for those undergoing substance abuse treatment. In a pattern that parallels the experience of many survivors of domestic violence, female substance abusers are often introduced to and supplied with drugs by male partners. Among the myriad reasons for continuing use are to maintain a relationship, to please a partner, or to share a common activity. Since safety poses such a serious problem for survivor clients, reevaluating ties to her significant other in the context of her goals for recovery requires careful consideration. For many of these women, recovery will not be possible without separation from their partners—a reality that may be extremely difficult for them to acknowledge, accept, and translate into action. Furthermore, because of the toll that the battering has taken on many survivor clients' belief in their ability to make decisions, they are likely to need additional help in evaluating and identifying sources of stress in their relationships. Despite the time and effort involved in working through this issue, however, it is not uncommon for survivor clients to change their views about which relationships feel safe as they begin to make choices that support recovery.

When working with some survivor clients, substance abuse treatment providers may have to discard traditional notions about the wisdom of making major life decisions, such as moving, early in the course of treatment. For a domestic violence survivor who fears being pursued by a batterer, relocation to another community may be a priority. As part of treatment, the stress of uprooting herself and her children and the accompanying risk of relapse must be weighed against safety issues. Should a client decide to move, every effort should be made to refer her to appropriate resources and supportive services within the new community.

Ensuring emotional health

Posttraumatic stress disorder

Posttraumatic stress disorder (PTSD) is a psychiatric diagnosis described in the *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994). The first diagnostic criteria are being "exposed to a traumatic event in which . . . (1) the person experienced, witnessed, or was confronted with an event or events that included actual or threatened death or serious injury, or a threat to the physical integrity of self or others [and] (2) the person's response involved intense fear, helplessness, or horror" (American Psychiatric Association, 1994, pp. 427–428). Other criteria include recurrent nightmares, difficulty sleeping, flashbacks, hypervigilance, and increased startle responses—symptoms shared by many battered women (Walker, 1991; Douglas, 1987; Follingstad et al., 1991; Woods and Campbell, 1993). One study of 77 battered women in a shelter found that 84.4 percent of them met the PTSD criteria in the DSM-IV (Kemp et al., 1991). Though the DSM-IV states that the disorder is "more commonly seen in association with an interpersonal stressor (e.g., childhood sexual or physical abuse, domestic battering, being taken hostage, incarceration as a prisoner of war or in a concentration camp, torture)" (p. 425), some domestic violence support workers have been reluctant to acknowledge PTSD among survivor clients. Their fear is that thus labeling the victim moves the onus for the violence from the abuser to the victim and provides another excuse for the batterer's behavior (e.g., "she's crazy"). A treatment provider, however, must be aware of the possibility that a survivor may be suffering PTSD and must make the appropriate referral.

Emergence of trauma from childhood abuse

Many survivor clients also suffered abuse as children (Browne and Finkelhor, 1986). Emotional and psychological trauma from childhood abuse is often repressed and may surface once the client is in a safe setting, such as an inpatient substance abuse treatment facility. The emergence of this memory can be an overwhelming experience, and treatment providers should not attempt to address it before the survivor is ready or if program staff are unprepared to handle the results. If the issue surfaces in a group setting, the substance abuse counselor should allow the survivor client to express her emotions initially. Thereafter, however, a client should be referred if possible to a therapist with special training in treating victims of childhood abuse.

Life event triggers

Recovering substance abusers are trained to deal with relapse triggers—events or circumstances that produce cravings and predispose them to resume their use of alcohol or other drugs. A potential trigger for relapse can be something as seemingly benign as walking through a neighborhood where the recovering individual once purchased drugs. A domestic violence survivor is vulnerable to an additional set of triggers—situations or experiences that may unexpectedly cause her to feel the fear and victimization she experienced when being battered. Such life event triggers may cause the client to relapse and should be addressed directly by counselor and client. Examples of life event triggers are sensory stimuli (sights, sounds, smells); the close physical proximity of certain people, particularly men; or situations that trigger unpleasant memories (such as witnessing a couple arguing). They also include stressful situations that evoke trauma responses and recreate the sense of victimization (Craine et al., 1988). Such triggers may push these feelings to the surface many years later, after the survivor is out of the abusive relationship; some disappear over time, but others may always be present to some degree. Counselors should help patients identify these stressful situations and rehearse alternative responses, just as they should for substance use triggers.

Increased stress with abstinence

Survivors of domestic violence usually experience strong emotional reactions when they stop abusing alcohol or other drugs, which may have been a form of self-medication. They may be flooded by formerly repressed emotions and physical sensations. Abstaining from substance abuse, which often helps a survivor repress her responses, may also eradicate her ability to psychologically dissociate (distance herself emotionally so she does not "experience" feelings) from what was happening during the abuse. This dissociation may have provided her with an effective coping mechanism that allowed her to function on a day-to-day basis, despite the abuse. Its elimination may give rise to somatic symptoms, such as headaches or backaches, as formerly blocked physical sensations and experiences reenter her awareness.

Another issue for the survivor upon becoming abstinent may be the freeing of time and energy formerly spent procuring alcohol or other drugs, leaving her feeling empty or directionless and with too much time to dwell on her life situation. Other problems may surface as well. In the Panel's experience, eating disorders as well as other kinds of obsessive-compulsive behavior tend to reemerge after substance abuse ceases. Treatment providers should be alert to this possibility and prepared to refer survivor clients for specialized help (such as a local eating disorders program or chapter of Overeaters Anonymous).

Perceptions of safety

Paradoxically, the very concept of "safety" may itself seem "unsafe" to a survivor of domestic violence. As one survivor expressed it, "The minute you (think you) are safe, you are not safe." For these clients, feeling safe from the perpetrator, even if he is dead or incarcerated, is equated with letting one's guard down and making oneself vulnerable to attack. Survivors tend to be hypervigilant and are accustomed to always being on guard. The substance abuse treatment provider needs to understand and respect the domestic violence survivor's concept of and need for safety. Helping a client rebuild a more appropriate general level of trust is an important long-term therapeutic goal.

Medications

For some survivors, anxiety, depression, suicidal thoughts, and sleep disorders are severe enough to require medication during their treatment for substance abuse. In such cases, it is of utmost importance to strike a balance between the need for medication and the avoidance of relapse. On the one hand, the recurrence of the physical and emotional sequelae of abuse may tip a survivor into emotional trauma; on the other hand, however, the client may risk relapse with the possible misuse or abuse of the medication. Physicians should weigh carefully the risks and benefits of prescribing drugs to battered women for symptom relief. For battered women who use or are dependent on alcohol or other drugs, the drug may affect their awareness, cognitive reasoning, or motor coordination, which can, in turn, reduce their ability to protect themselves from future incidents of physical abuse. A thorough medical and psychological assessment should be conducted by a trained clinician experienced in addiction medicine before any psychoactive medications are prescribed. As with other medicated substance abusers, regular monitoring and reassessment of symptoms are essential.

Later Postabstinence Issues

Practical concerns overwhelm many survivors of domestic violence after they become abstinent. These include resolution of legal problems, housing, transportation, employment or supported vocational training, and child care, among others. Linkages with other programs and agencies become extremely important in meeting these clients' needs. (See Chapter 6 for a discussion of the importance of forming collaborative relationships.) In addition, there are some special concerns that merit particular attention when working with survivor clients. "Welfare to Work," "Workfare," and other initiatives designed to rapidly move welfare recipients into employment may prove especially problematic for these clients. Both Panel members and reviewers described the inordinate pressure survivors experience when they are compelled to accept several new responsibilities at the same time. Panel members recommended developing, if possible, a schedule for the graduated assumption of responsibilities. Field Reviewers concurred and observed that providers should plan on providing extra support during this crucial postabstinence period.

In addition, survivor clients are likely to need education or reeducation about meeting sexual needs without drugs or alcohol. Referral to or staff training by experts in this area is recommended to ensure that this topic is approached sensitively. In addition, classes in healthy nutrition are a useful adjunct to treatment for survivor clients as for other substance abusers.

Social functioning

Although a strong family or friendship support system can be invaluable to substance abusers as they reenter the mainstream from the drug culture, the domestic violence survivor who is recovering from substance abuse may find it especially hard to reestablish ties, make new friends, or, in some cases, build a completely new life for herself. Social isolation is common among domestic violence survivors, as batterers curtail their victims' contacts with friends and family members. While a survivor client will likely need help and advice about creating a new nondrug, nonviolent social milieu, treatment providers should be careful not to make decisions for her, but rather support her in finding new activities and pastimes. Many women who are victims of domestic violence are surprised to discover that they have a continuum of choices, especially in social situations: The idea of enjoying a party without getting intoxicated, for example, may not have occurred to a survivor in the past.

Parenting

Parenting is an issue for many substance abusers but may be a special challenge for survivor clients. The time spent in treatment initially may provide a respite from the concerns of parenting for many mothers, and the resumption of child care may be a source of additional stress. Some children become extremely needy after separation from their mother, and their demands could trigger a relapse or provoke an episode of violent behavior on her part.

An additional stressor may be the fact that some children are not supportive of their mother's choices. For example, they may not like her decision to separate from her abusive partner. They may pressure her, become depressed, act out, and try to coerce her into going home. This can create extreme conflict as the survivor client struggles to act in the best interests of her children. To further complicate the situation, it is not uncommon for older children (particularly boys) to ally with the batterer and become verbally or physically abusive to their mother.

To handle these issues effectively, a postabstinent domestic violence survivor may need to learn new parenting skills that take into account the realities of her status as a domestic violence survivor. These clients and their children commonly have a great deal of suppressed rage; handling frustration and anger is a crucial life skill that must be addressed directly in treatment. If treatment providers have not been trained in anger management and violence prevention, survivor clients should be referred to domestic violence support programs for these services.

Financial and legal concerns

Discussing the realities of everyday living and plans for the future that may increase the client's chances of a successful recovery is essential to the design of an effective treatment plan. Treatment providers should explore with the client her plans for future education and employment and should have information available about a variety of options. Through linkages with other agencies, the treatment provider can also help the client develop realistic plans for addressing any legal issues that may be unresolved and are interfering with recovery.

Relapse prevention

Domestic violence survivors who are newly abstinent may feel overwhelmed by pressures inherent in the responsibilities just described. For many, harassment and threats from their partners will be a continuing concern, and custody disputes and divorce hearings may further complicate their lives. All of these factors are potential triggers for relapse to which the provider should remain attuned. However, as a number of Field Reviewers pointed out, revictimization by their abusive partners poses the greatest risk of relapse for battered women. Whether these women remain in the relationship or not, the likelihood of revictimization is great—domestic violence is a highly recidivistic crime (Zawitz et al., 1993; Browne, 1993). Careful attention to recurring episodes of violence is essential to working with survivor clients to prevent relapse and, if relapse does occur, to minimizing its negative effects.

Issues for Children Of Survivors

Children of domestic violence survivors have special problems and needs that may not be readily apparent to the substance abuse treatment provider. Often this is because the more obvious, acute needs of the mother tend to eclipse those of her children. Children's issues must be addressed; if ignored, they can become antecedents to more severe problems, such as conduct disorders or oppositional defiant disorders.

Emotional and Behavioral Effects Of Violence on Children

Children of survivor clients typically display strong feelings of grief and loss, abandonment, betrayal, rage, and guilt. Older children also may have feelings of shame. Some indications that such feelings may be developing into serious problems for the child include

- Emotional lability
- Aggression
- Hostility
- Destructive behavior
  - Toward others
  - Toward objects or animals
  - Toward self; self-mutilation
- Inappropriate sexual behavior
- Regressive behavior
  - Bedwetting
  - Thumb-sucking or wanting a bottle (older child)
  - Rocking
  - Needing security objects (i.e., blankets)
  - Not speaking
  - Dependent behavior (i.e., demanding to be carried) (Kalmuss, 1984; Arroyo and Eth, 1995; Bell, 1995).

The child of a survivor may have his or her own, less apparent triggers for emotional trauma that may be quite different from the mother's. Children's triggers generally have to do with abandonment and separation issues, particularly if the children have been in foster care. Possible problem behaviors include the child's becoming overly clinging and needy upon reuniting with the mother, being fearful of a separation from her again, and acting out with hostility and violence to gain attention.

Children of survivors may also become "parentified," trying to be "perfect." Often this is the result of the child's feelings that he or she is somehow to blame for a parent's anger and subsequent violence. These children may also become extremely protective of their mothers. Other children may have somatic complaints, such as hives, headaches, stomachaches, or other unexplained aches or pains.

Children's responses to family violence vary according to individual temperaments and their age at the time the violence occurred. Posttraumatic symptoms, including sleeplessness and agitation, are common among children who experience violence within the family home (Pynoos, 1993). Some young children exposed to domestic violence may demonstrate regression in toileting behaviors and emotional distress (Arroyo and Eth, 1995). Developmental delays and language disorders also have been linked to parental domestic violence (Kurtz, 1994; Arroyo and Eth, 1995). Some school-aged children become more aggressive and anxious and lose ground academically (Pynoos et al., 1987).

Adolescents who have observed their fathers abusing their mothers exhibit high levels of aggression and acting out, anxiety, learning difficulties in school, revenge seeking, and truancy. Children who witness or experience domestic violence are at increased risk of adopting these same strategies in their interactions with their partners and children (Bell, 1995; Kalmuss, 1984). They may also become hypervigilant to the point of immobility or, in extreme cases, catatonia.

Assessment of Children's Needs

Some substance abuse programs allow children to accompany the mother to the facility where she receives services. Depending on the program's resources, children can be assessed at that time, treated onsite with counseling groups that coincide with adult sessions, or referred to a qualified children's treatment or counseling program for concerns such as

- Foster or kinship care (relative or nonrelative)
- Separation issues
- Behavioral, mental health, or emotional problems
- Physical health problems
- Safety.

Collaboration With Children's Services

Ideally, substance abuse treatment programs will establish collaborative relationships with children's programs available through public and private, nonprofit, family service mental health and developmental assessment agencies. In many areas, these programs provide sophisticated case management services that access respite care, home aid, and parenting skills training that are beyond the scope of most substance abuse treatment programs. Collaboration with such specialized programs would free substance abuse counselors to concentrate on providing treatment to their survivor clients. The family services case manager would assume responsibility for making linkages with the myriad institutions that affect the mother through the child, including

- The school system
- The health care system

- Social services and employment programs
- The child welfare system
- The criminal justice and civil court system
- Other community-based agencies (including family preservation and support).

Children's protective services agencies

Some survivor clients may be or will become involved with children's protective services (CPS) agencies because their children have been or are being abused and neglected. Since many battered women fear that CPS will take their children from them, they may resist efforts to involve CPS, and some will undermine their treatment to do so.

Treatment providers must adhere to the laws in their States regarding mandated reporting of child abuse and neglect even though clients may perceive those actions as a betrayal of trust. One way to minimize problems is to discuss reporting requirements and the procedures the treatment program follows prior to treatment. Providers should also establish working relationships with CPS to ensure an appropriate and best-case response to the family situation and the child's protection.

The Role of Treatment Providers In Supporting the Mother

The substance abuse counselor is involved with the children—directly or indirectly—through the mother. A key responsibility, then, is to understand how to interact with and support the mother in her parenting role.

Substance abuse treatment counselors must understand that the mother may be involved with multiple agencies, all of which make demands on her limited time and energy. To help her focus on her abstinence, treatment providers should

- Help the mother identify and coordinate the various services she needs via external case management services or, if unavailable, by acting as an advocate on her behalf.
- Support her efforts to participate in and take advantage of these services.
- Listen empathetically as she voices her frustration about the difficulties of meeting the demands made by the various agencies and service programs with which she is involved.
- Help her clarify the sometimes mixed messages she receives from these agencies, each of which tends to consider its "problem area" a priority (and, as a corollary, ensure that the substance abuse program's messages do not contribute to her confusion and frustration).
- Serve as an intermediary and advocate when other agency providers ask her to do more than is reasonable given her progress in treatment (e.g., resume custody before she is prepared to take on responsibility for her children or begin working while still striving to maintain abstinence).

Treatment providers also can assist survivor clients by inviting staff from domestic violence agencies such as Homebuilders and from CPS, jobs training agencies, and other organizations involved with domestic violence survivors to the substance abuse program so they can better understand the treatment and recovery process. Substance abuse treatment counselors also should request cross-training in domestic violence support as well as in-service training on the mission and operation of those agencies that come in contact with survivor clients.

Summary

As the chapter makes clear, survivors of domestic violence present unique substance abuse treatment challenges. Because domestic violence can be so psychologically damaging, particularly if it has been sustained since a client's childhood, a treatment provider should refer to domestic violence experts whenever possible. The treatment provider must also be careful not to unintentionally place the survivor client in danger by making inappropriate recommendations.

Central to the discussion of survivors' issues is the overarching need for informed, ongoing collaboration with the agencies that can help the survivor rebuild her life. Substance abuse treatment providers should try to facilitate this collaboration to the greatest extent possible. Treatment outcomes are substantially improved when interventions encompass all the relevant areas of a client's life, services are coordinated, inconsistent messages and expectations are reduced, and the effects of both domestic violence and substance abuse are well understood by all those interacting with the survivor client.

Case Scenario: Profile Of a Survivor

Judy, a white high school graduate in her late 20s, is a recovering substance abuser and a survivor of domestic violence. Her story is typical of the many problems and circumstances faced by women who enter both the domestic violence support and substance abuse treatment systems.

She was molested by her uncle from the age of 3 until she was 10; the molestation included vaginal penetration. Like many victims of sexual abuse, Judy was threatened by her abuser and never disclosed the abuse. On one occasion, her mother asked whether her uncle had ever touched her, and she replied, "No, he does nice things for me."

At age 15, she became sexually active with her 23-year-old boyfriend, Alex. Alex and she began using marijuana. When she was 18, she started using cocaine with Alex, who was now occasionally slapping her and forcing her to have sex.

At that time, she also discovered that she was pregnant. She decided to have the baby but received only sporadic prenatal care. During her pregnancy, both Judy and Alex used cocaine and marijuana and drank alcohol. The infant, a girl named Candace, was born at full term but was small for her gestational age. Alex left Judy soon thereafter, and she and Candace moved in with a new boyfriend, Billy. He used drugs and was both extremely possessive and violent. He intimidated Judy and sometimes threatened to kill her, Candace, and himself.

When Candace was 3, Judy, then 21, became pregnant again. Billy did not welcome the pregnancy and began hitting her in the abdomen and breasts when he was angry. Judy received no prenatal care during her second pregnancy and delivered a preterm, small-for-gestational-age baby whom she named Patricia. Neither Judy nor her baby was screened for drugs or HIV before or immediately after the birth.

By the time Patricia was born, Judy's drug use had escalated to include crack and increasing amounts of alcohol. Despite her mounting problems, Judy recognized that her new baby was a poor feeder. Judy was frightened enough to keep a 6-week postdelivery pediatric visit during which Patricia was diagnosed as "failing to thrive." At the same visit, 3-year-old Candace was weighed and found to be only in the 10th percentile of weight for her age.

Two weeks later, Judy and Billy were arrested on drug charges—Judy for possession and Billy for dealing. She received probation, and she and her children moved in with her mother, Vivian. Billy was incarcerated, and Judy was required by the court to participate in substance abuse treatment.

In a group therapy session in her substance abuse treatment program, Judy acknowledged her history of family violence, childhood sexual abuse, and battering. Her case manager in this program wanted her to join another group of childhood incest survivors, but Judy felt ashamed and did not want to discuss the incest further. She began attending treatment sessions sporadically and, after 2 months, dropped out. In the meantime, tension developed between Judy and Vivian. Judy felt that her mother cared more for her granddaughters than she had about Judy when she was a child. Now that Judy had acknowledged her history of sexual abuse, she found herself blaming her mother for "allowing" it to happen. She also was jealous because she felt that Vivian was a better mother to Patricia and Candace than she was.

After a series of violent fights with her mother, Judy moved out and got a minimum-wage job, leaving her children with Vivian.

Around this time, Judy met Cody, a drug dealer. Cody moved in with her, but their relationship was characterized by frequent arguing and mutual battering. Judy's work habits became erratic; she often had bruises and sprains that she refused to discuss when her concerned coworkers questioned her about them. Although she saw her children infrequently, she would call late at night when she was high and criticize Vivian for keeping her children from her.

Meanwhile, under Vivian's care, Candace gained weight but exhibited a language delay. Her preschool teacher called Vivian repeatedly about Candace's problem behavior and acting out; she was having trouble paying attention in school, was defiant to her teachers, and was domineering with her peers. The school also reported that Candace had language problems and that she frequently cried for her mother.

Meanwhile, Vivian had quit her job in order to care for her grandchildren and was receiving Aid to Families with Dependent Children (AFDC). At this time, Vivian's health began to deteriorate, and she asked for help with Candace and Patricia. When a social worker began to talk about sending the children to a foster home, Judy was scared into action. Developmental evaluations were recommended for both children, and Judy took them to those appointments. Both children were found to have marginal developmental problems, possibly due to Judy's drug use during pregnancy. In response to the psychologist's advice, Judy enrolled Candace in a developmentally more appropriate preschool program that required parental involvement. Judy participated in this program with her daughter and resumed treatment.

For a brief time, Judy's life appeared to stabilize. Although she had not finished her substance abuse treatment program, she and Cody were both working, and she continued to receive negative screens for drugs (although she was still using occasionally). At the next CPS hearing, the children were returned to Judy's custody with the stipulation that she participate in parenting classes as well as continue in treatment.

Once her two children moved in with her and Cody, the situation began to deteriorate. Cody could not tolerate the children, and his episodes of violent behavior increased. He put his fist through the wall and kicked the door down. He became increasingly angry at Judy's frequent absences as a result of "all this kid stuff" (parenting classes and Candace's preschool program). He began to "spank" the children or grab them roughly by their arms when he wanted their attention. They showed up at their respective day care and preschool programs with bruises, which were attributed to "accidents." No one at the day care or preschool programs was aware of Judy's history or her disclosures of childhood abuse and battering in the treatment program.

Cody's violence continued to escalate and, increasingly, was directed at the children. While Judy was concerned about his hitting and yelling at the children, she didn't know what to do about it. She was feeling overwhelmed by her job, the parenting classes, her meetings with social services workers and her probation officer, and her child care responsibilities. In time, however, she began intervening when Cody yelled at or hit the children, deliberately provoking him in order to divert his attention away from the children and onto herself. The neighbors called 911 frequently, but the police never found any substantial evidence of violence.

A year passed with no improvement. The children continued to attend school, but Judy appeared only sporadically at her parenting classes and the preschool program. She was now beginning to suspect that Cody was sexually abusing 5-year-old Candace. She had begun to notice the same kinds of behavior in her daughter that she remembered in herself when she was sexually abused at that age. One day she asked Candace whether Cody had ever touched her in certain ways. Candace replied, "No, he is always nice to me." Candace remembered using almost identical words to her own mother years before and was certain that her daughter was being victimized in the same way. All the rage from her own abuse by her uncle erupted. She verbally and physically confronted Cody, and a battle ensued, which Candace witnessed. (Later this episode became a major treatment issue for the child, who believed that the violence in her household was her fault.)

Both Judy and Cody sustained injuries in their fight. Candace ran next door with her little sister, screaming about "all the blood." The neighbors called the police; Judy and Cody were both taken to the hospital, and the children were taken to a CPS emergency shelter. Judy and Cody were arrested for disturbing the peace and for possessing drug paraphernalia. Cody was charged with first degree (later reduced to third degree) assault, for which he eventually received a suspended sentence.

In the hospital, a social worker referred Judy and the children to a program for domestic violence survivors. After she was treated and released from the hospital, Judy stayed overnight in jail. The next day she was given a court appearance date, and a domestic violence advocate arranged transportation to the domestic violence program for her and her children. Program staff also assisted Judy in obtaining a restraining order against Cody and accompanied her to court to obtain it. When Candace and Patricia were reunited with their mother in the domestic violence facility, they clung to her, crying. Over the ensuing days, they experienced nightmares.

Despite the minor drug charge, the domestic violence program agreed to accept Judy because her drug screens were negative; the program had no knowledge of Judy's substance abuse treatment history. During intake, staff explained the program's drug use policy: If Judy used while in the program, her choices were to leave the facility or participate in treatment. The domestic violence program advocates did not think Judy was using drugs at the time of her admission and did not believe that she would use during her stay.

One day, Judy returned to the domestic violence program intoxicated, and a joint fell out of her purse. The program staff members saw and reported it to CPS. CPS then took away her children and again sent them to live with their grandmother. Judy's choices were now to either get substance abuse treatment or leave the facility. She entered a 1-year residential treatment program and was assigned to a counselor who was not only a recovering addict but a survivor of domestic abuse and with whom Judy felt an immediate rapport. The counselor and Judy together developed a treatment plan that took Judy's concerns and goals as well as the needs of her children into account. Although they agreed that intensive outpatient treatment would have been preferable, she had no place to stay where she would have been safe from Cody. She could not stay at the domestic violence program for that long, and Cody knew where her mother lived. Without a safe haven, her recovery and her life would have been in jeopardy, so Judy and her counselor decided on residential treatment. The counselor walked her through the admissions process.

Judy has been in recovery for 2 years, and her mother—who was encouraged to participate in family sessions—is supportive. Judy goes to work every day and has begun to date an older, recovering alcoholic she met at an AA meeting. He is more established and sees her children regularly. Vivian has again quit her job and is receiving AFDC. Cody is receiving substance abuse treatment and counseling for domestic violence, which were conditions of his suspended sentence. Another condition is that he remain in treatment and make no attempt to contact Judy or the children. The children are seen on a daily basis in the domestic violence program. But because the program can provide only supportive care and play activities, the children have been referred to a local agency with special supportive and mental health services for children.

3 Batterers: An Overview

There are myriad reasons why substance abuse counselors should address the domestic violence of clients who batter their partners. Consensus Panel members have observed that the violent behavior of a batterer client can interfere with his treatment for substance abuse, and conversely, his substance abuse can interfere with interventions aimed at changing his violent behavior (Bennett, 1995). Clients who are incarcerated, for example, or accused of assault or murder have limited access to substance abuse treatment. Practitioners have observed that for those clients in treatment, battering may precipitate relapse and thwart the process of true recovery, which includes "adopting a lifestyle that enhances one's emotional and spiritual health, a goal that cannot be achieved if battering continues" (Zubretsky and Digirolamo, 1996, p. 225).

Use of psychoactive substances, on the other hand, may interfere with a client's capacity to make a safe and sane choice against violence by impairing his ability to accurately "perceive, integrate, and process information" about another's behavior toward him (Bennett, 1995, p. 761). Intoxication appears to increase the likelihood that a batterer may misinterpret or distort a partner's remarks, demeanor, or actions by "blunting whatever cognitive regulators the abuser possesses" (Stosny, 1995, p. 36). While abstinence from drugs and alcohol does not alter battering behavior, substance abuse problems negatively affect a batterer's capacity to change and increase the chance that violence will occur (Tolman and Bennett, 1990; Bennett, 1995).

Both battering and substance abuse result in harm to the client and others. Responding to a client's penchant for violent behavior is as vital as responding to his depression or to the array of other conditions that may impede progress in treatment and interfere with recovery.

Perspectives on Substance Abuse and The Batterer Client

Although domestic violence occurs in the absence of substance abuse, there is a statistical association between the two problems. Alcohol use has been implicated in more than 50 percent of cases involving violent behavior (Roy, 1982). Research by Kantor and Straus suggested that approximately 40 percent of male batterers were heavy or binge drinkers (Kantor and Straus, 1987). A recent study found that more than half of defendants accused of murdering their spouses had been drinking alcohol at the time (Bureau of Justice, 1994). Another study of incarcerated batterers found that 39 percent reported a history of alcoholism and 22 percent reported a history of other drug addiction. A total of 50 percent self-reported current addiction; however, this figure rose to 89 percent when the researchers examined court documents. All but one of the subjects admitted to having been drunk at the time the battering occurred (Bergman and Brismar, 1994). Higher rates of substance abuse consistently correlate with higher rates of domestic violence, although one important study concluded that "[c]hronic alcohol abuse by the male rather than acute intoxication is a better predictor of battering" (Tolman and Bennett, 1990, p. 91). As one field reviewer noted, however, "Assaultive men, in general, have high alcohol use scores. Indeed the more a man matched the gauge for having an abusive personality, the greater his alcohol consumption. When a batterer says, 'the alcohol made me do it,' he's blaming one symptom—violence—on another—alcohol abuse."

Most Consensus Panelists and field reviewers concur that the exact nature of the correlation between battering and substance abuse remains unclear.

> Anger and hostility are more frequently generated by interactions between people, and alcohol or other drug use is likely to be linked to violent behavior through a complicated set of individual, situational, and social factor... The prevalence of violence between partners cannot be adequately explained merely as the consequence of alcohol and other drug abuse, nor can it be understood outside the context within which it occurs. (Gorney, 1989, p. 231)

Current research supports the finding that substance abuse is only one of many factors that influence a batterer's violent behavior (Collins and Messerschmidt, 1993). As with substance abuse, other factors are also correlated, such as depression, psychopathology, violence in the family of origin, social norms approving of violence (especially toward women), high levels of marital and relationship conflict, and low income (Tolman and Bennett, 1990; Bennett, 1995; Hotaling and Sugarman, 1986; Hotaling and Sugarman, 1990; Bograd, 1988). Although intoxication may trigger an individual episode of violence, addiction does not predispose one to be a batterer. This distinction is crucial for a provider to understand when treating batterer clients, because *a batterer's violence does not necessarily end when he stops abusing alcohol or other drugs.*

In characterizing substance abuse and domestic violence, practitioners have observed that the two problems are "separate but similar, and they each interact and exacerbate each other. For example, both problems are passed on from generation to generation; both involve denial, with substance abusers and batterers blaming victims for their behavior; usually, neither problem decreases until a crisis occurs; and secrecy is often the rule, with victims of abuse (wrongly) blaming themselves for their partner's substance abuse or violent behavior" (Engelmann, 1992, p. 6).

Profiling Batterers

In the past, research has focused more on attempts to identify characteristics of victims rather than perpetrators of violence (Hotaling and Sugarman, 1990). While information about batterers is relatively sparse and subject to some debate, it can provide the basis for a rudimentary understanding of their behavior. One caution is in order, however. Exploring batterers' individual characteristics addresses only one dimension of the domestic violence phenomenon. Some experts believe that battering is driven by socially supported sexism and inequitable distributions of power that feed the batterer's belief that he has an inherent right to control his partner's behavior. Others contend that analysis of batterers' characteristics has limited value if attention is not also directed to the larger culture of violence and social injustice in which battering occurs (Adams, 1988; Tolman and Bennett, 1990; Stosny, 1995). Research has clearly asserted the importance of socioeconomic factors in understanding battering: Approval of violence against women, low income, and belief in gender-based stereotypes emerge repeatedly as correlates of domestic violence (Bennett, 1995). As in the case of substance abusers, multiple internal and external risk factors appear to influence problem development among men who batter.

Individual Characteristics

Although batterers are a heterogeneous group, research has uncovered a number of characteristics that differentiate men who batter from men who don't. Many batterers (particularly those who engage in severe physical assaults against their partners) witnessed parental violence when they were children (Hotaling and Sugarman, 1990; Pagelow, 1984). While not replicated, findings from the large-scale National Family Violence Survey that included over 6,000 families suggest that experiencing corporal punishment as an adolescent may be a risk factor for later partner abuse (Straus and Kantor, 1994). As mentioned above, chronic alcohol abuse is another predictor of violence (Tolman and Bennett, 1990), and some studies have found that batterers are more likely to suffer from depression (Hamberger and Hastings, 1986a; Saunders and Hanusa, 1986).

Need for power and control

Many experts believe that batterers use violence or the threat of violence to achieve a sense of control, both over their victims and generally (Gondolf, 1995). Violence may also reflect a personal need for power and domination over others. Gondolf, building on McClelland's theory of alcohol and power motivation (McClelland, 1975), suggested that the need for personal power (reinforced by societal norms of male dominance) may be the factor that accounts for the high correlation between substance abuse and spousal abuse. According to this theory, men who have a high need for power over others are more likely to abuse alcohol and to use violence. Alcohol provides an illusion of power; so does beating one's wife. In some cases, a batterer who is drunk can gain instant control of his wife—and in a sense his entire marital situation—by terrorizing her. Furthermore, if the violent incidents are stopped through intervention, arrest, or treatment, the lack of control perceived by the batterer often increases not only the frequency of assault, but its severity as well.

In addition to inflicting physical pain and injury, a batterer may also abuse his partner psychologically and emotionally. A batterer attempts to control the thoughts and feelings of the partner by monitoring her behavior, making her accountable for his emotional highs and lows, denigrating her, criticizing and blaming her, and calling her names. Nonphysical abuse generally targets the victim's sense of self-esteem, well-being, and autonomy. *Psychological abuse* can be defined as behavior intended to control the victim's actions and functioning in everyday life (often by making her fearful). It may take the form of isolating her from her friends, family, and other sources of support or keeping her from having money to pay bills and other expenses. Another form is threatening physical harm—not only to the victim but to family members, friends, or himself. It can also be the "silent treatment": The batterer may refuse to speak directly to the victim for extended periods, such as days or weeks, leaving her guessing about how she has displeased or offended him. *Emotional abuse* is denigrating, shaming, ridiculing, or criticizing the victim and otherwise attempting to damage or destroy her self-esteem. These types of abuse often accompany physical violence to some degree, although they can also occur in relationships that are not physically violent. It is unclear how men who batter differ from those who don't in the use of nonphysical forms of abuse (see Figure 1-1).

Any intervention with a batterer that does not concomitantly address issues of power and control may simply allow the batterer to become more sophisticated at other, nonphysical kinds of manipulation. To interrupt these types of abuse, couples and/or family therapy may be recommended once domestic violence experts ascertain that the victim is out of danger.

Role of anger

The precise role of anger in battering is unclear. When treatment for batterers was first being developed, some practitioners viewed anger as a primary cause of abuse and believed that imparting anger management skills would curtail and ultimately eliminate battering behavior; others viewed anger as just another excuse for violent behavior. Today, many researchers and practitioners consider anger as only one of a number of antecedents or precipitants for violence. Addressing the anger is not the same as addressing the larger problem of violence, but it may be a useful technique in preventing the expression of violence against intimate partners (Tolman and Saunders, 1988; Tolman and Bennett, 1990).

Consensus Panelists and field reviewers concur that although anger is a common emotional theme among violent batterers, a batterer's violence is not "caused" by anger. They also agree that while anger management groups can play an important treatment role, they caution that if such groups are not judiciously mediated by highly trained specialists in domestic violence, they may indirectly *reinforce* violent behavior. Inadequately facilitated groups can turn into "gripe sessions" that fuel batterers' anger instead of educating them about how to handle their feelings without resorting to violence. (For an informative debate about anger management and batterers' interventions, see Gondolf and Russell [1986] and Tolman and Saunders [1988].)

Another anger-related issue concerns the false belief that "explosive anger" is a hallmark of batterers (Stosny, 1995, p. 65), whereas, in reality, many batterers are afraid to reveal their anger to the outside world and successfully present themselves as victims to the clinicians charged with treating them ("nothing I do is right; she's always criticizing me"). Some clinicians look for overt anger and fail to find it, then label batterers as "in denial" about their anger. Treatment revolves around "getting batterers in touch with their anger and letting it out." Too often, this ill-conceived approach (which has been debunked by much contemporary literature) has had "disastrous consequences for both batterers and their loved ones" (Stosny, 1995, p. 66). When responding to batterers, it is important to understand the complex role that anger plays in both precipitating and sustaining violent behavior. Responsible treatment incorporates techniques for regulating as opposed to revealing anger (Stosny, 1995).

Substance abuse also skews the motivational mix of anger and battering in a variety of ways. Alcohol and other drugs often serve as mood regulators and anger management tools, which sometimes exert a calming effect, but also may intensify angry feelings. The Consensus Panel did not discuss the specific psychopharmacological effects of cocaine, amphetamine/methamphetamine, or phencyclidine or other hallucinogens on violence, because there is no evidence to suggest that these drugs have any effect on *domestic violence* (although a few studies suggest that chronic use may influence aggressive behavior in general [Brody, 1990]). Much like efforts to understand the links with alcohol, both research and experience indicate that personality, preexisting brain disorders, and environment also play important roles in the relationship between substance abuse, anger, and violence (Brody, 1990).

Attachment deficit and affect regulation

As clinicians and researchers have learned more about battering, some have begun to consider it within the context of an individual's total personality rather than as an isolated behavior. In this view, problems with attachment when young, compounded by the experience of growing up in a home environment marred by a father's violent behavior and shaming "put-downs," contribute to the development of a "violence-prone borderline personality [who is] ... addicted to brutality to keep his shaky self-concept intact. The only time he feels powerful and whole is when he is engaged in violence" (Dutton, 1995, p. xi). At the same time, the painful experience of rejection as a child has also bred a deep-seated fear of intimacy or "engulfment" (Dutton, 1988; Dutton and Browning, 1988).

Practitioners of psychologically based approaches to understanding and treating batterers are acutely sensitive to the criticism that they are excusing batterers on the basis of their underlying psychological problems (Dutton, 1995). Supporters of what is often termed the psychoeducational approach are quick to assert that psychological insights help to explain batterers' behavior; they do not justify or excuse it (Dutton, 1995; Stosny, 1995).

Group Typologies

While experts agree that the relationship between substance abuse and battering is far more complicated than cause and effect, some attitudes and patterns reappear in men who abuse their partners. In an effort to better understand and improve treatment for batterers, researchers have attempted to group them on the basis of common characteristics (Gondolf, 1988; Hamberger and Hastings, 1986a; Dutton, 1995; Saunders, 1992). Gondolf organizes batterers into three clusters:

1. *"Typical batterers"* (the largest group in Gondolf's sample, 52 percent) generally confine their violence to their families. For the most part, these men are not substance abusers, are unlikely to have significant mental disorders, have no arrest history, and tend to be remorseful after battering episodes. In contrast to other batterers, their behavior usually results in less severe abuse.
2. *Antisocial batterers* (41 percent of the sample) are extremely abusive and may be violent outside the home. This type of batterer is emotionally volatile; has some mental health problems, such as antisocial personality disorder, depression, or anxiety; and may be a substance abuser. He may be under the care of a physician or in mental health therapy. He may have difficulty attending or completing a batterers' program without receiving additional mental health services.
3. *Sociopathic batterers* (7 percent of the sample) comprise the most violent group. Although these men are likely to be heavy substance abusers, they are the hardest type to engage in substance abuse treatment. They have little empathy for others, no self-insight, and no feelings of guilt or remorse for their actions. They are the most likely of the three groups to have been arrested (Gondolf, 1988).

Hastings and Hamberger characterize batterers as having borderline personality disorder, antisocial personality disorder, or a form of compulsive personality disorder (Hamberger and Hastings, 1986a). Saunders looked at a range of variables including extent and levels of violence inside and outside the home, levels of anger and depression, attitudes toward women, substance abuse, conflicts in relationships, and need for power. According to his analysis, those who were violent outside the home were the most brutal batterers. They also were the most likely to abuse alcohol and to have been abused as children (Saunders, 1992).

In his work, Dutton has observed three types of batterers that he classifies as

1. *Psychopathic wife assaulters* (40 percent of the men in Dutton's program). These men meet the diagnostic criteria for antisocial behavior and resemble Gondolf's sociopaths as well as

those men in Saunders' cluster of men who are violent outside the home. Dutton believes that the prognosis for treatment is poor for this group. In his words, "psychopaths don't look back. As a result, they never learn from past mistakes" (Dutton, 1995, p. 27).

2. *Overcontrolled assaultive males* (about 30 percent of the men in the program). This group consists of men with an overriding need for control. In Dutton's experience, they tend to be "perfectionistic" and "domineering." They tend to use emotional abuse, including verbal attacks, harassment, and withholding of affection to "generate submission" (Dutton, 1995, p. 30). Overcontrolled assaulters are usually the most compliant clients in treatment.
3. *Cyclical/emotionally volatile wife abusers* (about 30 percent of the men in the program). These men fear intimacy and suffer from recurrent feelings of abandonment and engulfment. They are overly dependent on their partners and, as a result, are literally "either at their wives' knees or at their throats" (Dutton, 1995, p. 42). Common traits include "flat affect, noncommittal response, and limited emotional lexicon" (Dutton, 1995, p. 44). They are incapable of describing what they feel and tend to repeat the same complaints and accusations about their partners over and over again. However, it is this group of batterers who calculate exactly how severely they can injure their partners without leaving obvious signs of abuse. It is also this group who best fits the "phases of abuse" theory first described by Lenore Walker in her pioneering work on domestic violence (Walker, 1979). These men typically undergo a buildup of tension that explodes in an episode of acute battering and is followed by a remorseful apology and so-called "honeymoon period" of concern and attention (Dutton, 1995).

By their very nature, typologies are artificial constructs, subject to change as new information develops. Despite their limitations, however, these groupings suggest that substance abuse programs will encounter those batterers who are among the most difficult to treat. As an example, members of the Consensus Panel observed that unlike the cyclical/emotionally volatile wife abuser (above), many severe batterers, among whom substance abusers are overrepresented (Roberts, 1988), do not fit the patterns of behavior seen by Dutton and Walker. Instead of following up a battering episode with a period of remorse (Walker, 1979; Dutton, 1995), they use the postviolence period as an opportunity to blame the victim for starting the abuse or to break up with her, or both.

The following section of this chapter focuses on the batterer who is more likely to be seen in a substance abuse program. These men have multiple problems and function, for the most part, in socially and economically impoverished environments. Involvement with the criminal justice system is almost a certainty, although domestic violence may not be the cause. At this time, few evaluations exist of batterers' treatment and even the developers of the popular "Duluth model" (see Figure 3-1) "have no illusion that most men will stop their violence and give up their power" (Pence and Paymar, 1993, p. xiv). Nevertheless, efforts by Consensus Panel members, field reviewers, and Statewide Networks Against Domestic Violence (such as those in Virginia and Maryland, to name just two) indicate that batterers' treatment can be effective if programs place a premium on survivor safety (even though the batterer is the client), insist that batterers take personal responsibility for their behavior, mandate "no-violence contracts," impart emotional regulation techniques, follow up on treatment completers and dropouts, and evaluate program outcomes regularly (Stosny, 1995).

Figure 3-1

Models for Batterers' Intervention Programs

The "Duluth model," as it is commonly called, was developed at the Domestic Abuse Intervention Project in Duluth, Minnesota, (Pence, 1989; Pence and Paymar, 1993) and is probably the most widely used model for batterers' intervention programs in the United States. There are many variations on the Duluth model, but all feature victim safety and community coordination as cornerstones and require batterers' programs to be accountable to victims and to victim advocates. The Duluth model is based on confronting the denial of violent behavior, exposing the manifestations of power and control, offering alternatives to dominance, and promoting behavioral changes. It calls for communitywide intervention that employs the resources of law enforcement, courts, domestic violence shelters and advocates, health providers, and batterers' programs. A batterers' program cannot, in this model, exist without the other components in the network. Although some experts feel that the Duluth model tends to encourage shame and guilt rather than real change, it sees domestic violence not as a form of personal pathology, anger and hostility, or substance-induced behavior, but as an outcropping of men's socially sanctioned domination of women. Batterers' programs developed under this model are designed to educate men about power and control, not merely to assist them in managing anger or personal problems. Communitywide coordination ensures that batterers are arrested and prosecuted and that victims are protected.

The psychoeducational model promotes responsibility for violent behavior and the development of mechanisms for self-regulation, empathy or compassion for others, and appropriate emotional vocabulary to express intimacy. Safety precautions for significant others, no-violence contracts, provision of information, changing attitudes toward women, reinforcement or development of values via modeling, anger and stress management, and assertiveness skills are key features of this cognitive-behavioral approach (Palmer et al., 1992; Stosny, 1995). Group and individual treatment can be utilized within this model, although single-sex groups tend to be the norm. Results of one study suggest that highly structured groups (with defined curricula, homework assignments, and skilled facilitation) work more effectively than less structured groups (Edleson and Syers, 1990, 1991).

Couples therapy treats men who batter together with their partners, often in a group setting. This is a controversial approach to batterers' intervention that has fallen into disrepute because of concerns about partner safety, its "implicit message that both partners are equally responsible for the violence," and its failure to acknowledge the role of gender and historical power inequities (McKay, 1994, p. 36). Substance abuse treatment providers should not treat batterer-and-victim couples together without consulting a domestic violence expert.

Treatment Issues for the Substance-Abusing Batterer

Crisis Intervention and The Victim's Safety

Like any client entering substance abuse treatment, the batterer is typically in a crisis state when he first presents for services. He may have been referred to treatment by the courts after being arrested for drug- or violence-related charges, or he may have been left alone by a battered partner seeking safety for herself and the children. Even when his outward demeanor is calm and accepting, violence may be imminent.

Substance abuse counselors typically regard a crisis situation as a prime opportunity to intervene with a client and engage him in the treatment process. In this context, a crisis is frequently transformed into a positive event for both the substance abuser and those who care about him. With substance-abusing batterers, the situation is different. Because batterers tend to defer responsibility and to project their anger onto others, a crisis situation may spur a violent incident at home. Examples of crises that may precipitate violence include loss of employment, the impending loss of family relationships through separation or divorce, emotional and psychological breakthroughs during psychotherapy, a citation for driving while intoxicated, court-mandated treatment for substance abuse, being served with a restraining order, a partner's pregnancy, or the birth of a child. For this reason, when a substance-abusing batterer experiences a crisis, treatment providers should have a plan in place for addressing the fallout. Although it requires a shift in focus from the client to the family, the most immediate concern when a crisis occurs is the safety of those who have been or may become the batterer's victims, in particular his partner and children, whether they remain with the batterer or not (see Chapter 5 and Appendix B for specifics on notification procedures and conformance with Federal and State confidentiality regulations).

Family members, and in particular the client's partner, should be consulted regarding what is best for their safety (although the provider should bear in mind that their version of the situation may be somewhat skewed). Extreme caution and tact should be used to avoid further endangering the victim(s). If available, substance abuse counselors should refer and defer to trained violence support professionals or the partner's advocate to develop a safety plan that includes logistics for leaving the home quickly or, if she does not want to leave him, other strategies for increasing her safety.

Fostering Accountability

Because batterers tend to shift responsibility and blame onto others, the degree to which a client begins to assume responsibility for his actions can serve as a barometer for his substance abuse treatment progress. To that end, assessment and monitoring can be incorporated into the treatment plan to evaluate the degree to which the batterer is taking responsibility for his violent actions. The batterer's accountability can be highlighted by linking his actions with tangible consequences. One way to achieve this is through the use of a "no-violence contract" with clearly delineated sanctions for violation (see Chapter 4). The substance abuse counselor must also be familiar with and understand the legal status of the batterer and how it affects his access to ongoing treatment services.

In addition, the use of multiple screening measures such as the Revised Conflict Tactics Scale (CTS2) for couples (Straus et al., 1996) and the Psychological Maltreatment of Women Inventory (Tolman, 1989, 1995), both reproduced in Appendix C, can aid the treatment provider in determining the extent of abuse while focusing the batterer's attention on his behavior.

Batterers' Intervention Program Models

If available, collaboration with and referral to batterers' intervention programs can facilitate the treatment of substance abusing batterers. Some of the models being used today are summarized in Figure 3-1.

Abstinence

During screening and throughout the treatment process, substance abuse counselors should explore the context in which the batterer client uses alcohol and other drugs in order to identify the chain of events and emotions that preceded or accompanied particular instances of substance abuse and violent episodes. Based on their experience, the Consensus Panelists recommend eliciting the following information about the relationship between the substance abuse and the violent behavior:

- Exactly when in relation to an instance of substance abuse the violence occurs
- How much of the violent behavior occurs while the batterer is drinking or on other drugs
- What substances are used before the violent act
- What feelings precede and accompany the use of alcohol or other drugs
- Whether alcohol or other drugs are used to "recover" from the violent incident.

By understanding the dynamics of intoxication and abstinence as a precursor to violence, the treatment provider can formulate a treatment plan that incorporates strategies for ensuring the partner's and other family members' safety and for helping the batterer focus on modifying the behaviors and events that precipitate substance abuse and violence. The focus in treatment must be on encouraging the batterer client to develop enough self-awareness to recognize the beliefs and attitudes as well as to control the emotions that contribute to his violent behavior.

Bonding With Peers

Friendships with members of the same sex are generally seen as a positive expression of self-development in both male and female clients being treated for substance abuse. Treatment staff must be on the alert, however, for signs of collusion among male batterer clients who have formed close friendships during treatment. Although such bonds often help clients learn about forming close and trusting relationships with others and examine their behavior in relation to that of their peers, in some cases, violent behavior can be instigated or condoned among batterer clients who reinforce each other's excuse-making mechanisms (see Figure 3-2).

One field reviewer who works with batterers writes that

> In our anger management class, we pursue a new definition of manhood through the proper exercise of personal power. Personal power does not include violence of any kind, except for self defense. Personal power involves the negotiation of a system that is often seen as indifferent and hostile in a productive way—giving the batterer an opportunity to feel powerful in a rational manner. We redefine manhood in terms of emotional cost-benefit analysis and problem solving. Clinically, it appears to be working.

Parenting

Many substance abusers, male and female, have poor parenting skills, whether or not they are in a battering relationship. An examination of the client's parental role is essential to understanding his violent behavior, since a batterer may use alcohol, other drugs, or violence to respond to conflict within the family structure. Young boys often learn violent behavior from male role models. Among the challenges in substance abuse treatment for batterer clients are to

- Raise the batterers' awareness of the impact of their violence on their children's future behavior
- Help batterers adopt other, nonviolent modes of behavior through anger management and coping skills training
- Reinforce the importance of modeling nonviolent behavior in their interactions with their partners as well as their children.

The effects of a batterer's violence on his children has important implications for his treatment plan. Although family therapy is often an effective component of substance abuse treatment, this approach is inadvisable for the violent batterer until he has learned to take responsibility for his behavior and has learned how to respond to crises without using violence. Given the potential for harm to both partner and children, the Consensus Panel recommends postponing family and couples counseling until the batterer has demonstrated a pattern of nonviolent and noncoercive behavior for a given period of time (usually a year). The decision to provide or refer for family or couples therapy also should be conditional upon whether or not the victim freely chooses to participate in counseling (the request should be made privately; *a victim should never be asked to make that decision in a batterer's presence*). Until these conditions are met, the batterer should be treated independently of other family members.

Ongoing Support

Over the past 50 years, the substance abuse treatment field has grown and developed into a national network of 12-Step groups, church affiliations, and social systems. In contrast, there are no ongoing organizations that support change for men who batter or for their victims.

Figure 3-2

Positive and Negative Aspects of Bonding Among Batterers

Positive

- Support for change
- Amelioration of feelings of isolation; support for communicating experiences with others
- Help in dealing with crisis
- Friendships

Negative

- Support for control and dominant behavior over partners
- Support of counterproductive activities (e.g., having multiple sexual partners)
- Support of negative parenting activities (e.g., having children by different women)
- Support for a negative definition of *manhood*
- Support for believing he is correct and does not have to negotiate or compromise
- Access to information on how to violate laws such as orders of protection
- Use of alcohol and other drugs
- Opportunity to participate in "gripe sessions"—tirades against women under their control
- Reinforcement of perceived victim status

Although some batterers may enter an aftercare program following substance abuse treatment, most do not. Widely scattered groups called Batterers Anonymous (BA) (Goffman, 1984) have not been totally embraced by domestic violence workers because their emphasis on participant anonymity appears to be incompatible with the violence field's focus on accountability. Some Consensus Panel members fear that, unless a batterer has already successfully completed a batterers' program, groups like BA may unwittingly encourage misogyny (see Figure 3-2). On the other hand, some field reviewers who work with violent substance-abusing clients have found that the antiviolence messages of BA and similar groups appear to help batterers contain their violence by emphasizing the consequences of violent behavior. Accredited or certified domestic violence programs are sound resources for information and referrals to appropriate batterer self-help support groups.

A number of batterers' intervention programs are beginning to offer aftercare services. Some are experimenting with mentors, who fulfill roles similar to sponsors in 12-Step programs. In this approach, a recovering batterer, under the supervision of a batterers' program or shelter that ensures his accountability, mentors a batterer who has completed a batterers' program. Continuing contact is essential because program completion is not necessarily an indication of whether a participant has stopped or even reduced his use of violence and coercion.

4 Screening and Referral of Survivors and Batterers in Substance Abuse Treatment Programs

It is crucial for substance abuse treatment providers to learn if their clients are either perpetrators or victims of domestic violence as early as possible in the treatment process. This chapter details signs to look for and techniques for eliciting information about domestic violence, which many affected clients are understandably reluctant to discuss. The suggestions and recommendations in this chapter are presented primarily for substance abuse treatment providers who work with clients involved in domestic violence as either batterers or survivors. They may also prove helpful to those providing domestic violence support services to their clients who have concomitant substance abuse problems.

Screening

Because of the well-documented relationship between domestic violence and substance abuse (Leonard and Jacob, 1987; Kantor and Straus, 1989; Amaro et al., 1990; Pernanen, 1991; Windle et al., 1995), and because domestic violence affects survivors' and batterers' recovery from substance abuse (Cronkite and Moos, 1984; Smith and Cloninger, 1985), the Consensus Panel recommends that all clients who present for substance abuse treatment services be questioned about domestic violence. Questions should cover childhood physical and sexual abuse as well as current abuse. (See Appendix C.)

Screening for domestic violence in substance abuse treatment settings is undertaken to identify both survivors and batterers. The domestic violence assessment, like the other elements of a substance abuse assessment, gathers the specific and detailed information needed to design appropriate treatment or service plans (Sackett et al., 1991). While the Consensus Panel believes that addictions counselors can be trained relatively easily to screen clients for domestic violence, assessment services are more complex and require in-depth knowledge and skill. Assessment should be conducted by a domestic violence expert if possible.

Once it is determined that a client is a victim of domestic violence, a provider must determine the client's needs for violence-related services such as medical care and legal advocacy. In addition to identifying violence as an issue affecting substance abuse treatment planning, another important purpose of screening for domestic violence is to ensure the safety—both physical and psychological—of a survivor client. (A word of caution: There is a tendency to think of residential treatment as a safety zone for both batterers and survivors with substance abuse problems. Domestic violence experts, however, note that batterers in treatment frequently continue to harass their partners by circumventing program rules and threatening them by phone, by mail, and through contacts with other approved visitors. Telephone and other communication and visitation privileges should be carefully monitored for identified batterers and survivors in residential programs.)

Methods of Screening For Domestic Violence: Survivors

Substance abuse treatment providers and domestic violence support staff use different terms to describe the screening process. Domestic violence programs refer to the initial contact with a client as *intake*, which is roughly analogous to what substance abuse treatment providers refer to as *screening*. Once a woman has been accepted to the program, domestic violence staff will conduct a *psychosocial intake*, which is similar to *assessment* in the substance abuse treatment field.

Clues for the Substance Abuse Treatment Provider

The most obvious indicator of domestic violence is the presence of physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts. Many survivors of domestic violence may be reluctant to seek medical treatment because they are afraid that documentation of violence in the household will result in their children being removed or because they are afraid of further violence as a result of the disclosure. These women may get their injuries treated at a number of different clinics or emergency rooms in order to avoid documentation of recurrent injuries.

Other indicators may include a history of relapse or noncompliance with substance abuse treatment plans; inconsistent explanations for injuries and evasive answers when questioned about them; complications in pregnancy (including miscarriage, premature birth, and infant illness or birth defects); stress-related illnesses and conditions (such as headache, backache, chronic pain, gastrointestinal distress, sleep disorders, eating disorders, and fatigue); anxiety-related conditions (such as heart palpitations, hyperventilation, and panic attacks); sad, depressed affect; or talk of suicide (McKay, 1994). According to Consensus Panelists and field reviewers, many batterers intensify their physical attacks when they learn their partner is pregnant.

Another clue is documented or reported child abuse perpetrated by the partner of a client. Evidence suggests that a father who abuses his children often abuses his wife as well (Bowker et al., 1988). Providers should be alert to the possibility that the mother of a child who has been or is being abused by her partner is also being abused herself.

The provider can also glean information from a woman's description of her partner's treatment of her. Behaviors that suggest he may be abusing her include

- Isolating her (keeping her away from family, friends, and others who are supportive of her recovery from substance abuse)
- Forcing her to sell drugs or prostitute herself for drugs
- Preventing her from attending treatment or 12-Step meetings
- Threatening to harm her, himself, or others
- Engaging in reckless behavior that endangers himself or others
- Damaging property or belongings
- Harming other family members or pets

- Threatening to abandon her or to take children away.

During an initial interview, many survivors will deny that they have been battered. Therefore, treatment staff must be alert to indicators of possible domestic violence and must continue to pursue them, with sensitivity and tact, over the course of treatment.

Conducting the Interview

Screening for domestic violence should take into account the client's cultural background and environment. Interviewers should be knowledgeable about the social mores of clients' groups and trained to avoid culturally bound stereotypes and jargon. Anecdotal evidence suggests that female interviewers may be more effective at working with survivors.

A substance abuse treatment provider who suspects that a client is being abused by her partner must use caution and tact in approaching this subject. Timing is important, too; in most cases, more information about a survivor's experience of violence will begin to emerge as she gains confidence and as treatment staff continue to foster an atmosphere of trust and respect. It is important not to ask potentially painful questions too soon; otherwise, a client may feel overwhelmed and reluctant to return.

Screening for domestic violence is more likely to be effective when the interviewer offers concrete examples and describes hypothetical situations than when the client is asked vague, conceptual questions. If using a yes/no questionnaire, interviewers should be prepared to follow up on "no" answers.

Another helpful screening technique is to focus questions on the behavior of the client's partner in order to ameliorate any discomfort she may feel in talking directly about herself. An important caveat to this recommendation, however, is that the interviewer should beware of "bad-mouthing" or otherwise attacking the batterer, as doing so may cause the abused client to defend the batterer and assume the role of his ally.

Setting is also important in asking clients sensitive questions about their home lives. Privacy and an atmosphere of trust and respect are necessary if the interviewer expects to obtain candid answers to screening questions, especially since survivors may for many reasons be unable to tell the whole truth about being abused. It is of utmost important for treatment staff to be aware that a client who may be a survivor of domestic violence should never be asked about battering when she is in the presence of someone who might be her batterer. In fact, providers should always interview clients about domestic violence in private, even if the woman requests the presence of another person who is unlikely to be her batterer. It is not uncommon for batterers to manipulate friends and family members into relaying information they heard in the interview that would put the client at risk. Her potential abuser may be a boyfriend or spouse, a stepfather or father, a mother's boyfriend, or a male sibling. Querying her in the presence of the abuser can seriously endanger her and may place her at risk of reprisal. In addition, obtaining accurate information from a survivor is highly unlikely in this situation.

Uncovering past sexual abuse

The Consensus Panel recommends that treatment providers ask about the substance-abusing client's family of origin in a way that gives the client "permission" to talk about it openly. For example, providers might preface their questions with, "In most homes where there is substance abuse, families have other problems, too. I'm going to ask some questions to see whether any of these things have happened to you or your family." Again, the interviewer should keep reassuring the client of confidentiality and safety while asking the following questions:

- "Were you ever told by an adult to keep a secret and threatened if you did not?"
- "Were you ever forced to watch sex between other people?"
- "Were you ever touched in a way you didn't like?"
- "How old were you when you first had sex (including anal, vaginal, and oral penetration)?" Then, "How old was the person you had sex with?"

Uncovering current abuse

Discussion of childhood abuse may open the door to discussion of current violence. In moving the interview from past to current violence, the possibility that they are survivors should be explored first, before questions about perpetrating violence themselves. This initial screening can be done by asking questions such as

- "Do you feel safe at home?"
- "Has anyone in your family ever physically hurt you?"
- "Has anyone in your family made you do sexual things you didn't want to do?"
- "Have you ever hurt anyone in your family physically or sexually?"

At this point, the interviewer can ask more specific questions regarding the nature and circumstances of specific incidents. Three questions have been cited as key to identifying victims of domestic violence:

- "Have you been hit, kicked, punched, or otherwise hurt by someone within the past year? If so, by whom?"
- "Do you feel safe in your current relationship?"
- "Is there a partner from a previous relationship who is making you feel unsafe now?" (Feldhaus et al., 1997).

The interviewer might go on to say, "We will be talking about these situations at different times throughout your treatment, and I want to know about any upsetting experiences that you may have had. Even if you don't feel like talking about this with me today, it is important that we eventually address all aspects of your life." The client should also be asked about her thoughts, feelings, and actions in particular situations. Questions (such as the following) about marital rape and nonconsensual sex should be included:

- "Do you feel comfortable with the ways you have sex?"
- "Has your partner ever forced you to do anything sexually that made you feel uncomfortable or embarrassed?"
- "Do you feel you can say no if you don't want to have sex?"
- "Are you ever hurt during sex?"
- "How do you feel about talking about safe sex and HIV with your partner?"

The interviewer needs to keep in mind that the client who has been sexually assaulted by her partner may normalize her experience, particularly if it has been a repeated one. If sex has always, or nearly always, been accompanied by violence or substance abuse, she may believe this is typical of all sexual relations.

If it becomes evident during a screening interview that a client has been or is being abused by her partner, the following four key questions can help delineate the frequency and severity of the abuse:

- "When was the first time you were [punished, hurt, or whatever word reflects the survivor's interpretation of abuse]?"
- "When was the last time you were abused?"
- "What is the most severe form of abuse you have experienced?"
- "What is the most typical way in which you are abused?"

Sometimes pointing to a body map is easier for a survivor client than naming where she has sustained injuries from battering (see Appendix C). It is also important to include questions about the extent of her injuries and the batterer's involvement in the criminal justice system.

Framing the questions

The interviewer should be aware that many survivors of domestic violence see the batterer's substance abuse as the central problem or cause of the abuse, believing that "if he would just stop drinking (or taking drugs)," the violence would end. In framing screening questions, it is extremely important to convey to the survivor that there is no justification for the battering and that substance abuse is no excuse. Questions such as, "Does he blame his violence on his alcohol or other drug use?" or, "Does he use alcohol (or other drugs) as an excuse for his violence?" serve the dual purpose of determining whether the client's partner may be a substance abuser while reinforcing to her that substance abuse is not the real reason for his violence.

Nor should questions feed into the batterer's excuse-making mechanism. The interviewer can shift the focus and the blame for the abuse away from the survivor by asking her questions about the batterer such as "Has he always handled problems by getting violent?"

Cultural considerations

In keeping a client-centered perspective, treatment providers must be aware of cultural factors that bear on the survivor's view of her experience and her willingness to talk about it. For many survivors, being battered is often a source of great shame that must be kept secret at almost any cost. Others may be unaccustomed to talking about family matters openly and directly with nonfamily members. To put the client at ease as much as possible, it may be helpful and appropriate for the interviewer initially to seek her permission to ask the screening questions, using language such as: "In order to help you, I need to know about what has been happening in your home. May I ask you some questions about you and your [partner, boyfriend, husband]? Or would you rather be asked these questions at another time?"

Respecting the survivor's sense of privacy in this way can boost her sense of control over her present situation. This can be especially important in light of the fact that most survivors present for services in a crisis. For example, a battered woman who seeks help with a substance abuse problem may have been abandoned by her abusive partner or may be in drug withdrawal. Her general feelings of powerlessness may be eased somewhat by this approach.

Although most women who are victims of abuse appear to respond better to a female interviewer, a client should be asked, and granted, her preference (Bland, 1995; Minnesota Coalition for Battered Women, 1992). If translators or hand signers are needed, a neutral party (not a family member) should be enlisted to perform this function.

Barriers to an accurate screen

As mentioned previously, it is common for a survivor of domestic violence to evade the issue or lie when asked about her abusive experiences. Survivors' reasons for lying about being abused are numerous and varied. Many blame themselves for the violence and make excuses for the batterer's erratic or destructive behavior. For example, a client who has been battered by her partner may attempt to justify his behavior with comments such as, "I deserved it," "I nagged him," or, "It was my fault." It is common for a survivor to believe that if only she would stop upsetting the batterer, or "pushing his buttons," the abuse would stop (American Medical Association, 1994). As one field reviewer noted, this self-blame may be more a mechanism to explain the violence that dominates survivors' lives than to justify it.

Some survivors go further than downplaying and self-blame and deny that there is abuse.

Such denial may be a functional mechanism for her that helps her avoid dealing with problems that seem overwhelming and insurmountable. Denial is also, in some cases, an adaptive survival technique developed as a direct response to unsuccessful attempts to obtain help. Additionally, the survivor of domestic violence may not be entirely truthful because she may be accustomed to using manipulation as a survival mechanism. Because survivor clients do not know how interviewers will use information about battering, they do not always divulge it.

Finally, as discussed in Chapter 2, many survivors have concrete reasons for hiding domestic violence. A survivor could lose custody of her children if it is discovered that they live in a violent household. And the batterer may well have told her that he will beat or kill her or her children if she reports the abuse.

Screening for Domestic Violence: Batterers

Screening Techniques And Questions

A discussion of family relationships is an element of all substance abuse screening interviews. Based on their experience, the Consensus Panel recommends using this component of the interview to address the issue of domestic violence with male clients. To initially gauge the possibility that the client is being abusive toward his family members, the interviewer can ask whether he thinks violence against a partner is justified in some situations (Kantor and Straus, 1987). This is the concept of "circumstantial violence." It is best to explore this possibility using a third person example so as not to personalize the question or make the client feel defensive; for example: "Some people think that, under certain circumstances, it's OK to hit your wife (girlfriend, etc.). Under what circumstances do you think violence might be justified?"

The answer reveals clues about whether and when a client might use violence against his partner. The interviewer can now shift the questions to the client himself. The interviewer can ask questions to assess the client's sense of self-efficacy and self-control:

- "If you were faced with overwhelming stress (use a hypothetical situation), do you think you could keep your cool?"
- "What do you think you'd do?"

Specific questions about events in the client's family, particularly his own current worries, may provide a sense of the environment in which violence may be occurring.

Part of an interviewer's aim here is to give the client a good reason to discuss the violence in a manner similar to that described for interviewing survivors—to help the client see that there are benefits to acknowledging the abuse. The interviewer may tell the client that violence toward a partner is not uncommon among the other people enrolled in a treatment program, opening the door for the client to respond truthfully.

By taking an open-ended social and family history, the interviewer can gradually move to specific, direct questions regarding violence and abuse in the current relationship. For example:

- "Have you ever been physically hurt by someone in your family?" If the client's partner has hurt him or her, the reverse may also be true.
- "Have you ever hurt someone in your family?"
- "Have you ever physically controlled, hit, slapped, or pushed your partner?" (If yes) "When was the last time this happened?"

Some batterers are so focused on their substance abuse problems that the violence is relatively unimportant to them. Others have lived with violence for so long that they have little understanding of the nature of their own behavior. Such individuals may provide information about their abusive behavior only incidentally or may dismiss it as unimportant. In their *Guidelines for Talking to Abusive Husbands* (EMERGE, 1995), experts from the EMERGE domestic violence support program recommend that providers:

- Ask specific, concrete questions (e.g., "What happens when you lose your temper?").
- Define violence (e.g., "When you hit her, was it a slap or a punch?" "Do you take her car keys away? Damage her property? Threaten to hurt or kill her?").
- Find out when the violence occurs and who the target is.
- Be direct and candid. (Resist the urge to use a euphemism such as, "Is your relationship with your partner troubled?" because you are uncomfortable asking the question. Instead, talk about "his violence" and keep the focus on "his behavior.")
- Become familiar with batterers' excuses for their behavior:
    - *Minimizing*: "I only pushed her." "She bruises easily." "She exaggerates."
    - *Citing good intentions*: "She gets hysterical so I have to slap her to calm her down."
    - *Use of alcohol and drugs*: "I'm not myself when I drink."
    - *Claiming loss of control*: "Something snapped." "I can only take so much." "I was so angry, I didn't know what I was doing."
    - *Blaming the partner*: "She drove me to it." "She really knows how to get to me."
    - *Blaming someone or something else*: "I was raised that way." "My probation officer is putting a lot of pressure on me." "I've been out of work."
- Don't be manipulated or misled by excuses. (Identify violence as a problem and hold the client responsible for his actions.)

Avoiding Collusion

Avoiding the implication that substance abuse is the "cause" of violence is as important in screening batterers as it is in screening survivors. Batterers often blame the victim, the victim's substance abuse, or their own substance abuse for the battering. In asking screening questions such as those just described, substance abuse treatment providers must be careful not to enable a batterer to place the blame for the battering on the victim or the drug. Interviewers must neither directly nor indirectly support the batterer's assertion that some other force has caused the violence or substance abuse (Cayouette, 1990).

An example of collusion would be the interviewer's assent that the client drinks because of some external source of stress, such as his job or his wife's "nagging." It is common for the survivor herself to think, feel, and act in accordance with this view, so often a tacit agreement exists between a batterer and a survivor to blame the latter for the violence. The client's failure to take responsibility for his behavior is further reinforced when a treatment provider or other team member speculates that circumstances, rather than the individual, are the cause.

Interviewing the Partner

Since clients who disclose their violence toward their partners often minimize its frequency and severity, experienced domestic violence staff may interview the batterer's partner in order to obtain salient information about his dangerousness to himself, his partner, and others. In fact, many batterers' programs require batterers to give permission for staff to interview the female partner as a prerequisite for acceptance into the program. This type of collateral interviewing, however, is quite different from that practiced in the substance abuse treatment setting and *requires specialized skills and expertise*. Prior to conducting the interview, violence support staff and the involved partner carefully weigh the risks associated with participating in such an interview (e.g., the possibility that it may precipitate another battering incident). If the partner agrees to the interview, she will be interviewed alone. Her perspective will be compared with the batterer's and used carefully and sensitively by the violence specialist in working with the batterer. (Appendix C presents an example of a survivor questionnaire that is used as a tool in assessing a batterer's dangerousness.)

Many substance abuse treatment providers routinely facilitate therapy sessions with substance abusers and their families. However, this approach *should not* be used with substance-abusing batterers and their partners. While substance abuse programs can cooperate with batterers' programs by reinforcing "no violence" messages and behaviors, providers should refer the client to a domestic violence specialist for further assessment and intervention. Some batterers' programs will not accept active substance abusers. In that case, participation in a batterers' program can become a specified part of the aftercare plan (Engelmann, 1992).

Screening for Presence Of Child Abuse

When family violence comes to the attention of the treatment provider, it is essential to determine whether children have been present or have been involved in any way. During the initial screening of the client, the Consensus Panel recommends that the interviewer should attempt to determine whether the children have been physically harmed and whether their behavior has changed (e.g., they have become mute or they scream or cry).

The confidentiality regulations spelled out in Title 42, Part 2, of the *Code of Federal Regulations* require that a client be given notice regarding the limitations of confidentiality—orally and in writing—upon admittance to a substance abuse treatment program (see Appendix B). *Inquiries into possible child abuse should not occur until this notice has been given and the client has acknowledged receipt of it in writing.* Great care must be taken when approaching either a batterer or a survivor of domestic violence about whether any children in the household have been abused.

There may be a number of barriers to obtaining a complete and accurate picture of the children's situation from these clients. First, adults who abuse children are generally aware of the laws that require substance abuse treatment providers, among others, to report suspected child abuse to agencies such as children's protective services (CPS), and they tend not to volunteer such information for fear of recrimination. Second, a survivor may be aware that her perceived "failure" to protect her children from violence may have implications for her retaining custody of them. Such fears are likely to be reinforced by her feelings of shame and guilt over "letting it happen." Or she may be abusing the children herself.

It is not advisable for the substance abuse treatment provider to perform an assessment of children for abuse or incest; this function should be performed by personnel with special expertise. The substance abuse treatment provider should, however, note any indications of whether abuse of children is occurring in a client's household and pass on what they find to the appropriate agency.

Indications of Child Abuse

In the Consensus Panel's experience, clues to possible child abuse may be obtained by questioning the client regarding

- Whether CPS has been involved with anyone who lives in the home
- Children's behaviors such as bedwetting and sexual acting out

- "Special" closeness between a child and other adults in the household
- The occurrence of "blackouts": Batterers often claim blackouts for the period of time during which violence occurs.

This area of questioning need not be repeated for each child in the household, but rather can be done in a general way in order to get a sense of the overall family environment.

If a treatment provider suspects that the child of a client has been a victim of violence, he or she must refer the child to a health care provider immediately. If it appears that the parent will not take the child to a doctor (who is required by law to report the suspected abuse), the provider must contact home health services or CPS. This should be done even if a child appears to be unharmed, because some injuries may not be immediately apparent.

Immediate attention to the child's emotional state is also important. Emergency room physicians or nurses who conduct physical examinations may not be in a position to thoroughly assess the impact of abuse on the child's emotional status. Initially, it may be that the most that can be done is to reassure the child that he is safe and will be taken care of. Ideally, however, he should be referred to a therapist who specializes in counseling traumatized children.

Reporting Suspected Neglect or Abuse

Clients must be informed that mandated reporters, a category that includes substance abuse treatment providers, are required to notify CPS if they suspect child abuse or neglect (see Chapter 5, Legal Issues). In addition, a client can be informed of the right to report his or her partner's abuse of children. Whatever decision is made concerning who will actually notify CPS, ultimately it is the mandated reporter's responsibility to ensure that this is done.

The treatment provider must assess the impact on a survivor client of reporting suspected or confirmed child abuse or neglect. If she cannot be protected from her abuser on a 24-hour basis, she may become the object of his violence if he blames her for the report, so a safety plan should be developed. It is equally important to prepare for the impact of reporting child abuse on the children and on the family as a whole. The possible results of such a report must be considered and explained to the client in advance. For instance, if CPS is unable to confirm that abuse or neglect has occurred, the children could be endangered if the abuser learns of the report. In other instances, CPS may remove the children from the home until further investigation can be undertaken. If the investigation confirms abuse or neglect, a series of court appearances will be required, and children may be placed in foster care either in the short or long term. In any case, it is imperative for professionals working with family members to provide information about what to expect and, if at all possible, talk with the CPS caseworker and accompany the family to court hearings. Child abuse and neglect is a complicated issue and will be discussed in detail in a pending Treatment Improvement Protocol.

Referral

When answers to screening questions suggest that clients may be either batterers or survivors of domestic violence, the Consensus Panel recommends an immediate referral to a domestic violence support program. When referrals are not possible, ongoing consultation with a domestic violence expert is strongly encouraged. In some instances, clients have been mandated into substance abuse treatment by the courts. Participation in a battering program may be another court-mandated requirement. Substance abuse treatment providers should not hesitate to use the leverage provided by the criminal justice system to ensure that clients who batter participate in batterers' treatment as well.

Referring Survivors

If, during the screening, the client reveals that she is in immediate danger, the counselor needs to attend to this danger before addressing other issues and, if necessary, should suspend the interview for this purpose (Sullivan and Evans, 1994). The treatment provider should be familiar with methods for de-escalating the situation or obtaining help (see Appendix D for a safety plan) and may advise the client to take some simple legal precautions and to safeguard important documents (see Figures 4-1 and 4-2). If the client and counselor decide to involve the police, they should first discuss possible reprisal by the batterer and plan a response.

A substance abuse treatment provider may be the first person to whom the survivor has revealed her victimization. Whether she has previously disclosed the abuse to other agencies or programs will have a bearing not only on the level of danger she is in or perceives herself to be in, but will also have an impact on the process of establishing linkages with other agencies and sources of support.

If screening reveals domestic violence, then further assessment is required. Though the substance abuse treatment provider should help the client build a safety plan, assessment is best performed by a domestic violence support program. Questions that will aid referral include

- "To whom have you talked about this in the past?"
- "Are you, or is anyone in your family, currently in danger from someone in your household? Do you think that being here now, talking to me, could put you in danger? If so, how?"

Figure 4-1
Safeguarding Important Documents

As part of the survivor's safety plan, it may be helpful to advise the survivor client to keep important documents in a safe deposit box or in a place where her partner cannot gain access to them. These materials may include some or all of the following:

- Social security documents
- Marriage license
- Passport(s)
- Copies of any protective orders or divorce or custody papers
- Green card
- Children's birth certificates
- Information about medical history, including vaccination schedules for children and records on health care visits
- Extra sets of home and car keys
- Photographic documentation of abuse
- Deeds or leases that document residence, titles to cars
- Other financial documents such as savings deposit books and payment books

If a survivor client expresses concern about the safety of her children, especially if they are left in the care of the batterer while she is in treatment, this is the time to refer the client for shelter and legal advocacy. Resources can be identified by contacting a local domestic violence program, or, if one is not available, a State program. The National 24-Hour Domestic Violence Hotline (1-800-799-SAFE) is another resource for domestic violence programs. Substance abuse treatment facilities should ensure that these resources are readily available to their staff.

Figure 4-2

Gathering Documentation

All States have mandatory reporting laws for child abuse, but only some have or are developing such laws for reporting domestic violence. Some battered women's advocates support such laws because they "take the pressure off" the victims to report their batterers. Some domestic violence service providers also believe that it is the community's responsibility—not the victim's—to stop the batterer's behavior. Some States mandate the arrest of batterers whether or not their victims press charges, and some are proposing mandatory physician reporting of battering. Concerns have been raised, however, about preserving victims' ability to decide whether they want to become involved in the criminal justice system or in domestic violence programs. For this reason, such laws are opposed by some battered-women's groups, who believe they put women at greater risk.

Regardless of whether a survivor elects to pursue legal remedies, she is well-advised to document the nature and extent of the domestic violence she and her family have experienced by compiling copies of

- Criminal justice reports, including prior legal actions (e.g., restraining orders) against batterers
- Any previous CPS reports that can be obtained
- Hospital records and health history of the client

Complete criminal justice and medical records may be difficult to obtain. In the case of medical records, for example, survivors may have made visits to numerous institutions (e.g., clinics and emergency rooms) in order to avoid raising the suspicion of domestic violence. Issues of confidentiality also may be an impediment to obtaining these records. (See Appendix B for more information on confidentiality.) When clients are unsuccessful in compiling information from standard sources, their self-reports to substance abuse treatment providers, documented in their program records, can be used to fill in the gaps and to help support their claims. When entering notes into the client's record, however, it is important to include the facts as presented or observed. Records can be subpoenaed and "gratuitous comments or opinions" may be used against survivors in custody cases (Minnesota Coalition for Battered Women, 1992, p. 41).

Referring Batterers

When suspected batterers are identified during the screening process, substance abuse treatment providers should refer them to batterers' intervention programs as a key part of the treatment plan. With the client's signed consent to release information, substance abuse counselors can share pertinent information with domestic violence staff in an effort to ensure that both problems are addressed.

Well-run batterers' treatment programs may not be available in every community. Before initiating referrals, the Consensus Panel recommends that substance abuse treatment staff compile a list of potential programs and providers, check their credentials with domestic violence support programs for survivors or local battered women's shelters, and contact appropriate programs or specialists to establish agreed-upon referral procedures.

The confidentiality regulations do not inhibit such referrals as long as consent to release information has been obtained and the procedures detailed in Appendix B have been followed.

Treatment Concerns for Survivors and Batterers

Even though a provider has referred a client involved in domestic violence to a survivors' or batterers' program or incorporated participation in such programs as part of the aftercare plan, domestic violence remains an issue. The treatment provider should see that the following actions are taken, either by the substance abuse or violence program or by a case manager assigned responsibility for the client's holistic care.

The "No-Contact Contract"

Some survivors' programs require participants to sign a contract agreeing to have no contact with their batterers for the duration of the program. In addition to helping to ensure her safety, such contracts can provide opportunities for staff to evaluate a survivor's current attitudes toward and thinking about the batterer. Such "reality checks" can be helpful if, as is often the case, a survivor begins to believe the batterer's assurances that he has changed and is no longer violent. The staff can point out the reality of the situation if the batterer is still abusing alcohol or other drugs and has not changed his life in any significant way.

The "No-Violence Contract"

Batterers entering treatment for substance abuse can be required to sign a contract agreeing to refrain from using violence. While such "no-violence contracts" are most effective when linkages with batterers' intervention programs are also in place, they can help structure treatment by specifying an achievable behavioral goal. It is more difficult for clients to play one agency against another when all those involved in a particular case prescribe common goals. When the court has a role in mandating treatment services and specifying sanctions for failure to comply, clients have an added incentive to adhere to such stipulations as "no-violence" contracts. Consensus Panel members believe that the prospects for positive outcome (e.g., reductions in substance abuse and domestic violence) will be improved when substance abuse and batterers' treatment programs and the courts collaborate to ensure that needed services are provided, consistent behavioral messages are communicated, and consequences for violating contracts and other programmatic stipulations are upheld.

Recovery Pitfalls for Batterers And Survivors

A number of violence support experts, including members of the Consensus Panel, have observed a tendency among some substance-abusing batterers to twist the messages of 12-Step programs in order to evade responsibility for their violent behavior:

> Men in recovery often gain more tools of abuse from their distorted interpretation of 12-Step and treatment programs. One of the most frequently used tools by batterers in groups has been the label of codependent. Men use it to put down their partners, saying this means battered women are as sick or sicker than them, to define victims as at least partly responsible for their violence, and to manipulate women into feeling guilty and ashamed of their expectations that men stop abusing. (Cayouette, 1990, p. 3)

Providers should be alert to signs that clients are misinterpreting the 12-Step philosophy to justify or excuse continued violence, especially since 12-Step programs can play a valuable role in supporting batterers' treatment as well as recovery from substance abuse when its principles are followed rather than distorted (Wright and Popham, 1995). Men who have embraced the 12-Step model will often challenge the excuse-making of batterers, encouraging them to take responsibility for all their actions, including the domestic violence. (Cayouette, 1990).

Group therapy is an essential feature of most substance abuse treatment programs. However, members of the Consensus Panel who have worked extensively with substance-abusing survivors observe that survivors "may have an especially difficult time talking about past experiences if men are included in the group. Often, the safest and most comfortable time for her to discuss violence is during one-on-one sessions with her counselor. These sessions are also an opportune time to ask about her needs regarding the abuse" (Minnesota Coalition for Battered Women, 1992, p. 39). Survivors also appear to benefit by participating in same-sex groups that do not use confrontational techniques (Minnesota Coalition for Battered Women, 1992; Wright and Popham, 1995).

Ongoing Attention to Issues Of Domestic Violence

As discussed previously in this chapter, many survivors and batterers presenting at substance abuse treatment facilities do not disclose domestic violence on intake, and treatment providers must rely on signs of violence that become apparent as the client spends time in treatment. Ongoing attention to issues of domestic violence is particularly important in these clients not only because it may take time for them to begin talking about it, but also because as they become abstinent, additional issues arise that are integrally related to the violence (Prochaska et al., 1992, 1994a, 1994b; Snow et al., 1994; Velicier et al., 1990). As with substance abuse, the full dimensions of a domestic violence problem are seldom immediately clear and may emerge unexpectedly at a later stage in treatment. If this happens, questions posed during screening can be asked again, and a referral to a violence support or batterers' intervention program can be initiated.

5 Legal Issues

All jurisdictions in the United States have implemented regulations and laws designed to protect victims of domestic violence. The Violence Against Women Act (VAWA), which was signed into law by President Clinton in September 1994, strengthens many of these protections and outlines Federal as well as State enforcement provisions and penalties. The Federal penalties mandated by VAWA are more stringent than existing State penalties: The bill, for example, makes it a Federal offense to cross State lines in violation of a civil protection order. In order to provide useful advice and support, substance abuse treatment providers should be familiar with VAWA and with relevant State and local regulations as well as with the legal resources available to victims of domestic violence.

Substance abuse treatment providers should also have working relationships with the criminal justice system and local providers of legal and domestic violence services to whom they can refer a client with such problems. (See Appendix E for a listing of national programs and hotlines that can help providers identify local services.)

Federal Law

The Violence Against Women Act

VAWA is a civil rights statute that was passed as part of the Violent Crime Control and Law Enforcement Act (Public Law 103-322). Besides strengthening prevention and prosecution of violent crimes against women and children, the law made domestic violence a civil rights violation. What this means is that a victim of "crimes of violence motivated by gender" can bring a suit for damages in civil court in addition to any charges made in criminal court.

Some of the more important provisions of the law include

- Greater penalties for sex crimes
- Funding for States to improve law enforcement, prosecution, and services for female victims of violent crimes
- Increased security in public transportation systems and national and urban parks
- Funding for rape prevention and education programs, targeted to, among others, middle and senior high school students
- Enhanced treatment for released sex offenders
- The development of model confidentiality legislation
- Funding for programs for victims of child abuse as well as for individuals who are homeless, for runaways, and for street youth at risk of abuse
- The creation of a national domestic violence hotline
- Funding to improve mandatory arrest or proarrest (a policy stating that police will make arrests in domestic violence incidents) programs, to improve tracking of domestic violence cases, to increase coordination of

services, to strengthen legal advocacy, and to educate judges

- The prohibition of the purchase of firearms by individuals subject to a final civil protection order
- The implementation of more protections for battered immigrant women and children, including liberalization of the "battered spouse waiver" enforced by the Immigration and Naturalization Service (INS).

Some provisions of VAWA may be particularly important to women in substance abuse treatment who are also survivors of domestic violence. Under VAWA,

- Past sexual behavior or alleged sexual predisposition of the victim is no longer admissible evidence in civil or criminal proceedings involving sexual misconduct.
- New Federal criminal penalties apply to anyone who crosses a State line in order to commit domestic violence or to violate a civil protection order.
- Anyone who forces a spouse or domestic partner to cross a State line for these purposes also is subject to penalties.
- States are required to enforce civil protection orders issued by the courts of other States.
- Victims must have the opportunity to testify regarding the potential danger of the pretrial release of a defendant.
- Defendants are required to make financial restitution to victims.
- The U.S. Postal Service is required to maintain the confidentiality of shelters and individual abuse victims by not disclosing addresses or other locating information.

One of the most important aspects of VAWA is the civil rights remedy for gender-motivated violence mentioned above. Relief in civil court may include monetary damages, injunctions, or declaratory judgment to redress the civil rights violation.

As of this writing, at least one district court decision has been issued that upholds the provisions of VAWA. In *Doe v. Doe* (929 F.Supp.608 D.Conn. 1996), a woman sought damages for 17 years of "physical and mental abuse and cruelty" by her husband. He moved to dismiss the case on the grounds that VAWA was unconstitutional. The Federal district court denied the motion to dismiss and upheld VAWA's constitutionality. If VAWA withstands other pending challenges, it may become an important weapon for women seeking to break free from battering partners.

Welfare Reform

The issue of preventing domestic violence has important implications for welfare reform; when considered in conjunction with issues involving substance abuse treatment, the overall picture becomes extremely complicated. In fact, some States (such as Kansas) have established laws that require people receiving welfare to be screened, assessed, and treated for substance abuse. It is important for treatment providers to be aware of the issues involved; careful coordination of services with domestic violence workers can help to avoid serious problems (Raphael, 1996).

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Public Law 104-193), signed into law on August 22, 1996, calls for greater use of paternity determinations to enforce child support regulations. This can be problematic for welfare recipients who are victims of domestic violence. Abuse is often exacerbated or reactivated when legal action is taken against the batterer for child support. Many abused women are afraid to seek child support because they fear that doing so will result in the batterer being given visitation rights, which would force disclosure of their new location. Although current Federal law does provide "good cause" exemptions in a number of situations, including domestic violence, this option is used by fewer than 1 percent of welfare applicants nationally (Raphael, 1996; Zorza, 1995b). Providers should tell survivor clients concerned about confidentiality that these exemptions exist.

Local Laws: Civil Protection and Restraining Orders

The most common and easily obtainable mechanism of relief for victims of domestic violence is the civil protection order. This general term includes any injunction or other order (such as a restraining order) that is issued for the purpose of preventing violent or threatening acts against another person. Generally, these orders prohibit harassment, contact, communication, or physical proximity. Protection orders may be temporary or final and may be issued by a civil or a criminal court. Protection orders can be issued independently or as part of another proceeding, such as a divorce or criminal complaint, but are separate from support or child custody orders.

Statutes and case law in all States and the District of Columbia allow an abused adult to petition the court for an order of protection, and in most State courts, a parent or another adult can file for a civil protection order on behalf of a minor child (Klein and Orloff, 1993). Depending on the relevant statutes and case law on the books of any given jurisdiction, conduct sufficient to support issuance of a civil protection order can include

- Criminal acts (most commonly battery, but also criminal trespass, robbery, burglary, kidnapping, malicious mischief, and reckless endangerment)
- Sexual assault and marital rape
- Interference with personal liberty
- Interference with child custody
- Assaults involving motor vehicles
- Harassing behaviors
- Stalking
- Emotional abuse
- Damage to property
- Transferred intent (in which someone other than the petitioner is injured by violence directed toward the petitioner) (Klein and Orloff, 1993).

State courts have consistently upheld the constitutionality of domestic violence statutes. Civil protection order statutes have been held to rationally and reasonably uphold the State's interest in preventing domestic abuse, because these statutes do not

- Deprive abusers of liberty and interest in their homes
- Deprive abusers of their families or reputations
- Inflict cruel and unusual punishment
- Violate equal protection, due process, freedom of association, or free space.

In addition, courts have found that procedural aspects of civil protection orders do not violate the defendant's right to a jury trial. Most jurisdictions allow an individual to petition for civil protection with or without the aid of a lawyer. In fact, some courts have upheld laws that permit court clerks to assist petitioners in filing for protection orders.

Although the assistance of legal counsel is preferable, *pro se* representation—or self-representation—is an option for victims who cannot afford the services of an attorney. Pro se actions allow domestic violence survivors to seek the immediate protection of the courts, and it can also empower them as they seek to gain control of their lives. Furthermore, many areas lack attorneys who are able and willing to act as advocates for battered women, although in some jurisdictions lay advocates are available to counsel victims of domestic violence, help prepare court papers, and handle uncomplicated cases in court.

Other Legal Issues

For many clients, treatment for substance abuse includes an effort to acknowledge—to themselves and perhaps to others—the harm they have visited on family and friends. A victim of domestic violence will explore the role substance abuse played in the abusive relationship. A perpetrator of domestic violence may have agreed to enter treatment in lieu of trial or incarceration; he will need to examine that aspect of his behavior as well as his substance abuse. Finally, a client who enters treatment presenting an entirely different constellation of issues may disclose during the course of counseling that he or she has either assaulted or been assaulted by a spouse. During the course of counseling victims—or perpetrators—of domestic violence, substance abuse program staff will hear about violent behavior. What is the program's legal obligation in such circumstances? How should programs deal with inquiries from lawyers or criminal justice officials? What should a program do when a counselor or client records are subpoenaed or the police come armed with a search warrant? This section discusses these issues and the tension between the need to protect people from harm and the need to respect the client's confidentiality. Confidentiality is protected under 42 *Code of Federal Regulations* (C.F.R.), Part 2, implementing 42 U.S.C. §290dd-2. (All references to §2 . . . below refer to these regulations.)

Although the Federal confidentiality regulations may prohibit reporting domestic violence to law enforcement authorities, substance abuse treatment providers should still ask about it. Whether the information is passed along or not, it still bears on treatment. Providers should acknowledge the abuse; help the client separate her responsibility from that of the batterer; counsel her that the violence may escalate; help assess her safety and offer available options; clearly document the abuse (enlisting the aid of a forensic examiner, if necessary); provide referrals to shelter, legal services, and counseling; and facilitate such referrals with her consent. *Treatment providers must not let confidentiality restrictions prevent them from routinely inquiring about domestic violence in the course of providing appropriate care to clients.*

Reporting Child Abuse And Domestic Violence

What should a program do when a client admits he has battered his spouse at some time in the past—or during his participation in treatment? Does the program have a duty to call law enforcement officials if a woman threatens to assault her husband or child—an act the counselor knows she has committed in the past? What can a program do if a client attacks his wife at the program? These are three very different questions that require separate analysis.

Is there a legal duty to report past crimes?

The general question about the duty to report past criminal activity is one that arises frequently for substance abuse treatment programs. Many substance abusers engage in criminal behavior while they are abusing drugs and even during the course of treatment. In a situation in which a client has told a substance abuse counselor that he or she has battered a spouse or child in the past, there are generally three questions the program needs to ask as it considers whether to make a report: (1) Does State law require the program to make a report? (2) Does State law permit the program to make a report? (3) How can a report be made without violating the Federal law and regulations governing confidentiality of patients' records (42 U.S.C. §§290dd-2 and 42 C.F.R. Part 2)?

First, under State law, is there a legal duty to report child abuse or other domestic violence? For substance abuse counselors the answer to this question is "yes" if child abuse is involved and generally "no" if battering of a spouse is involved.

Reporting child abuse

All States (and the District of Columbia) require a broad range of care providers—including substance abuse treatment programs—to report when there is reasonable cause to believe or suspect child abuse or neglect. While many State statutes are similar, each has different rules about what kinds of conditions must be reported, who must report, and when and how reports must be made. In most States, failure to report may result in civil or criminal charges. All States extend immunity from prosecution to persons reporting child abuse and neglect; in other words, a person who reports abuse cannot be sued.

While all States require agencies to report child abuse, most alcohol and drug programs are limited by Federal law in the kind and amount of information they may disclose to anyone without a patient's written consent. (The regulations require that a particular form of written consent be used. Appendix B contains a full discussion of these regulations as well as a sample consent form.) However, the Federal confidentiality regulations do permit substance abuse treatment programs to comply with State mandatory child abuse reporting laws.

Note, however, that this is a narrow exception to the regulation's general rule prohibiting disclosure of any information about a client. It permits only initial reports of child abuse or neglect. Programs may not respond to followup requests for information or subpoenas for additional information, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report, unless the client consents or the appropriate court issues an order under §2.64 or §2.65 of the regulations.

Reporting domestic violence against adults

Assault of another person, including a spouse, is a crime. Few States impose a duty to report a crime committed in the past, although some States do require physicians treating certain types of injuries incurred as the result of a violent criminal act (e.g., a shotgun wound) to make a report to the police. Even those States that still have laws that require reports of past criminal acts rarely prosecute violations of the law. Therefore, unless a particular State should mandate reporting of spousal abuse by health care providers and mental health counselors, it is unlikely that a substance abuse treatment counselor will have a legal obligation to report.

When is reporting permitted?

Does State law permit counselors to report a crime involving domestic violence to law enforcement authorities? Whether or not there is a legal obligation imposed on citizens to report past crimes to the police, occasions may arise when counselors feel a personal obligation to report an admission of domestic violence to law enforcement authorities. However, State law may protect conversations between counselors of substance abuse programs and their clients (by making them privileged) or exempt counselors from any requirement to report past criminal activity by clients. Such laws are important to clients in substance abuse treatment, many of whom have committed offenses during their years of alcohol or drug abuse. If part of the therapeutic process for clients includes acknowledging the harm they have done others, substance abuse programs that routinely reported clients' admissions of past criminal activity would have limited ability to work with clients in the recovery process. Laws protecting conversations between counselors of substance abuse programs and their clients are designed to protect that relationship, an important part of the treatment process. Survivor clients as well as batterers need to know that their disclosures are protected.

State laws vary widely in the protection they accord communications between patients and counselors. In some States, admissions of past crimes may be considered privileged and counselors may be prohibited from reporting them; in others, admissions may not be privileged. Moreover, each State defines the kinds of relationships protected differently. Whether a communication about past criminal activity is privileged (and therefore cannot be reported without the patient's consent) may depend on the type of professional the counselor is and whether he or she is licensed or certified by the State.

Any program that is especially concerned about this issue should ask a local attorney for an opinion letter about whether there is a duty to report and whether any counselor-patient privilege exempts counselors from that duty.

Complying with Federal and State law

Any program that decides to report a client's admission of past spousal abuse must do so without violating either the Federal confidentiality regulations or State laws. A program that decides to report a client's admission of battering or any other criminal activity can comply with the Federal regulations by following one of these three methods:

1. If a criminal justice agency has required the batterer to enter treatment in lieu of prosecution or incarceration, and the batterer has signed a criminal justice system consent form that is worded broadly enough to allow this sort of information to be disclosed, the program can report the client's admission of a crime to the referring criminal justice agency. Generally, programs that treat such mandated patients agree to report progress in treatment, failure to attend treatment, and certain categories of criminal acts to the referring criminal justice agency. Mandated patients sign a special consent form permitting programs to do so. (A full explanation of criminal justice system referrals and consent form appears in Appendix B.) Note, however, that the Federal regulations limit what the criminal justice agency can do with the information. Anyone receiving information pursuant to a criminal justice system consent "may redisclose and use it only to carry out that person's official duties with regard to the patient's conditional release or other action in connection with which the consent was given" (§2.35(d)). Thus the disclosure can be used by the criminal justice agency that ordered the offender to enter treatment to revoke his or her participation in treatment in lieu of criminal justice processing, but most likely not to prosecute the batterer for a separate crime (in other words, for making the assault the program is reporting). Only if a special court order is obtained pursuant to §2.65 of the regulations (also explained in Appendix B) can information obtained from a program be used to investigate or prosecute a patient (42 U.S.C. §290dd-2(2)(C) and 42 C.F.R. §2.12(d)(1)).
2. The program can make a report in a way that does not identify the individual as a client in a substance abuse program. (Disclosures that do not identify the offender as someone with a substance abuse problem are permitted. See the explanation of §2.12(a)(1) in Appendix B.) This can be accomplished either by making an anonymous report or—for a substance abuse program that is part of a larger entity, say, a managed care organization—by making the report in the larger entity's name. For example, a counselor employed by a program that is part of a mental health facility could phone the police, identify herself as "a counselor at the Palm County Health Center," and report the assault. This would convey the

vital information without identifying the client as an alcohol or drug abuser. Counselors at free-standing substance abuse programs cannot give the name of the program.

3. The program can obtain a court order under §2.65 of the regulations, permitting it to make a report if the crime is "extremely serious." The program must take care that the court issuing the order abides by the requirements of the regulations. (Court orders are discussed in Appendix B.)

By using any one of these methods, the program will have discharged its reporting responsibility without violating the Federal regulations. Before reporting, however, the program should also be sure that a report would not violate any State laws making communications between clients and counselors privileged. Because of the complicated nature of this issue, any program considering reporting a batterer's admission should seek the advice of a lawyer familiar with local law as well as the Federal regulations.

Is there a duty to report threats?

In working with batterers, substance abuse treatment programs may face questions about their "duty to warn" someone of a client's threat to harm his spouse or child. Even when a counselor has no legal obligation to report a client's threat, a treatment professional may feel an ethical, professional, or moral obligation to try to prevent a crime.

Over the past 20 years, States across the nation have adopted a principle—through legislation or court decision—requiring psychiatrists and other therapists to take "reasonable steps" to protect an intended victim when they learn that a patient presents a "serious danger of violence to another." This trend started with the case of *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for money damages because he failed to warn a potential victim his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."

In most States, therapists and other care providers must warn a victim or the police when a patient makes a credible threat of violence to another identified person. (Of course, not every threat uttered by a patient should be taken seriously. It is only when a patient poses a serious threat of violence toward a particular person that the duty to warn arises.) Counselors who fail to warn either the intended victim or the police may be liable for money damages or license revocation.

In a situation where a client threatens to assault a spouse, and the counselor believes he is serious, the counselor must ask him- or herself at least two—and sometimes three—questions:

1. Is there a legal duty to warn in this particular situation under State law?
2. Even if there is no State requirement that the program warn an intended victim or the police, do I feel a moral obligation to do so?

The first question can only be answered by an attorney familiar with the law in the State in which the substance abuse program operates. If the answer to the first question is "no," it is advisable to discuss the second question with a knowledgeable lawyer too.

3. If the answer to the two questions above is "yes," can the counselor warn the victim or someone likely to be able to take action without violating the Federal confidentiality regulations?

The problem is that there is an apparent conflict between the "duty to warn" imposed by the many States that have adopted the principles of the *Tarasoff* case and the Federal confidentiality requirements. Simply put, the Federal confidentiality law and regulations prohibit the type of disclosure that *Tarasoff* and similar cases require unless a substance abuse program can use one of the Federal regulations' narrow exceptions. These aside, the Federal regulations make it clear that Federal law overrides any State law that conflicts with the regulations (§2.20). In the only case, as of this writing, that addresses this conflict between Federal and State law (*Hasenie v. United States*, 541 F. Supp. 999 (D. Md. 1982)), the court ruled that the Federal confidentiality law prohibited any report.

There are five ways a substance abuse treatment program can report a client who makes a serious threat to harm someone (or himself). The first three of those methods have already been outlined above in the discussion about reporting admissions of past crimes:

1. The program can make a report to the criminal justice agency that mandated the batterer into treatment so long as there is a criminal justice system consent form signed by the batterer that is worded broadly enough to allow this sort of information to be disclosed. (As noted above, the Federal regulations limit what the criminal justice agency partner can do with the information.)
2. The program can make a disclosure to the potential victim or law enforcement officials that does not identify the individual who has made the threat as a patient in substance abuse treatment. This can be accomplished either by making an anonymous report or—for a substance abuse treatment program that is part of a larger entity, such as a managed care organization—by making the report in the larger entity's name.
3. The program can go to court and request a court order in accordance with §2.64 of the Federal regulations, authorizing the disclosure to the intended victim, or in accordance with §2.65, authorizing disclosure to a law enforcement agency. The regulations limit disclosures to law enforcement agencies for the purpose of investigating or prosecuting a patient to "extremely serious" crimes, "such as one which causes or directly threatens loss of life or serious bodily injury, including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect" (§2.65). See Appendix B for a discussion of both court order exceptions.
4. The program can make a report to medical personnel if the threat poses an immediate danger to the health of any individual and requires immediate medical intervention (§2.51). Thus, for example, a program could notify a private physician about a suicidal patient so that medical intervention can be arranged.
5. The program can obtain the client's consent. This is extremely unlikely if the client is the batterer, and even survivor clients often do not want their batterer's threats reported to the law.

If none of these options is practical, what should a program do? If a program believes there is clear and imminent danger to a client or another person, it is probably prudent to report the danger to the authorities or the threatened individual, particularly in States that follow the *Tarasoff* rule. While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a program or counselor who believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn might well result if a threat were actually carried out. In any event, the program should try to make the warning in a manner that does not identify the individual as a substance abuser.

As in other areas where there are no clear-cut answers and the law is in flux, programs should find a lawyer familiar with State law who can provide advice on a case-by-case basis. Programs would also be well advised to establish a protocol ensuring that the clinical or program director has a chance to review the situation before a report is made. "Duty to warn" issues are an area in which staff training may be helpful.

What should a program do if an assault occurs on the premises?

The answer is more straightforward when a client has committed or threatens to commit a crime on program premises or against program personnel. In this situation, the Federal regulations permit the program to report the crime to a law enforcement agency or to seek its assistance. Moreover, in these circumstances, the program can disclose details about the incident, including the suspect's name, address, last known whereabouts, and status as a client at the program (§2.12(c)(5)).

Communicating With The Legal System

Counselors working with victims—or perpetrators—of domestic violence may find that lawyers, law enforcement officials, and others view them as a good source of information. A call from a lawyer asking about a client, a visit from a law enforcement officer asking to see records, or the arrival of a subpoena to testify or produce treatment records—what should a program do in each of these circumstances?

The answer is (1) consult the client, (2) use common sense, and (3) as a last resort, consult State law (or a lawyer familiar with State law).

Responding to Lawyers' Inquiries

Starting with the first scenario—a lawyer calls and asks about Jane White's treatment history or treatment. As a first approach to the question, Jane's counselor must tell the lawyer, "I don't know that I have a client with that name. I'd have to check my records." This is because the Federal confidentiality regulations prohibit any other response without the client's written consent. The regulations view any response indicating that Jane White is the counselor's client as an unauthorized disclosure that Jane White is in substance abuse treatment.

Even if the counselor has the client's written consent to speak with the lawyer, she may find it helpful to consult with the client before having a conversation about her: "I'm sure you understand that I am professionally obligated to speak with Jane White before I speak with you." It will be hard for any lawyer to disagree with this statement.

The counselor should then speak with the client to ask whether the client knows what information the caller is seeking and whether the client wants her to disclose that or any other information. She should leave the conversation with a clear understanding of the client's instructions—whether she should disclose the information, and if so, how much and what kind. It may be that the lawyer is representing the client and the client wants the counselor to share all the information she has. On the other hand, the lawyer may represent the client's spouse or some other party with whom the client is not anxious to share information. There is nothing wrong with refusing to answer a lawyer's questions, but a polite tone is best. If confronted by what could be characterized as "stonewalling," a lawyer may be tempted to subpoena the requested information and more. The counselor will not want to provoke the lawyer into taking action that will harm the client.

If the lawyer represents the client and the client asks the counselor to share all information, the counselor can speak freely with the lawyer once the client signs a proper consent form. However, if the counselor is answering the questions of a lawyer who does not represent the client (but the client has consented in writing to the disclosure of some information), the counselor should listen carefully to each question, choose her words with care, limit each answer to the question asked, and take care not to volunteer information not called for.

Visits by Law Enforcement

A police officer, detective, or probation officer who asks a counselor to disclose information about a client or a client's treatment records must be handled in a similar manner. The counselor should give a noncommittal response, such as "I'll have to check my records to see whether I have such a patient." Of course, if the patient was mandated into treatment in lieu of prosecution or incarceration, program staff may be obligated to speak with someone from the referring criminal justice agency, and the client will have signed a criminal justice system consent form authorizing the program to do so.

If the officer's inquiry has come "out of the blue," the counselor should speak with the client to find out whether the client knows the subject of the officer's inquiry, whether he wants the counselor to disclose information and if so, how much and what kind and whether there are any particular areas the client would prefer she not discuss with the officer. Again, the counselor must get written consent from the client before speaking with the officer.

If the counselor knows that a client is a fugitive from justice, a refusal to assist or give officers information is a criminal offense in some States.

Responding to Subpoenas

Subpoenas come in two varieties. One is an order requiring a person to testify either at a deposition out of court or at a trial. The other—known as a subpoena *duces tecum*—requires a person to appear with the records listed in the subpoena. Depending upon the State, a subpoena can be signed by a lawyer or a judge. Unfortunately, it can neither be ignored nor automatically obeyed.

In this instance, the counselor's first step should be to call Jane White—the client about whom she is asked to testify or whose records are sought—and ask what the subpoena is about. It may be that the subpoena has been issued by or on behalf of Jane's lawyer with Jane's consent. However, it is equally possible that the subpoena has been issued by or on behalf of the spouse's lawyer (or the lawyer for another adverse party). If that is the case, the counselor's best option is to consult with Jane's lawyer (after getting Jane's written consent) to find out whether the lawyer will object—ask the court to "quash" the subpoena—or whether the counselor should simply get the client's written consent to testify or turn over her records. An objection can be based on a number of grounds and can be raised by any party, including the person whose medical information is sought. Often, the counselor may assert the client's privilege for the client.

Dealing With the Police

A program may unknowingly admit a client who is sought by the police. If the police discover that someone they are seeking is at the program and come armed with an arrest warrant, what should the program do? How should programs handle search warrants? The answers to these questions are quite different.

Arrest Warrants

An arrest warrant gives police the authority to search the program facilities; however, the program is not authorized to help the police by pointing out the client they are seeking unless the client is being sought because he or she committed a crime on program premises or against program personnel. The unfortunate result is that the confidentiality of all clients in the program may be compromised when the police enter and search for a fugitive. There is no solution to this problem unless the police secure a court order under §2.66, which would authorize the program to disclose the identity of the client, or the program convinces the client to surrender. (Voluntary surrender by a client is a disclosure by the client, not the program.) It is usually in the client's best interest to surrender voluntarily, since arrest is probably inevitable and his cooperation may weigh in his favor with the prosecutor and judge when the question of bail arises. The risk is that the client will attempt to escape, which might expose the program to a charge of assisting unlawful escape. To reduce this possibility, the program should work with the police so that law enforcement personnel have secured the area around the program.

Search Warrants

A search warrant does not authorize the program to permit the police to enter the premises. Even if signed by a judge, a search warrant is not the kind of "court order" that the Federal regulations require before the program can allow anyone to enter and see clients or client records when clients have not consented. Law enforcement officials are unlikely to know about the restrictions of the Federal regulations, however, and they will probably believe that a search warrant permits them to enter and search the program. What should a program do?

Presented with a search warrant, program staff should show the officer a copy of the Federal regulations and explain their restrictions. Staff can suggest that the officer obtain a court order that will authorize the program to make the disclosure called for in the search warrant. No harm will ordinarily be caused by resultant delay (although the police may not agree with this view). The program should call its lawyer and let him or her talk with the police. Failing that, a program could try to call the prosecutor who has sent the police, explain the regulations, and point out that any evidence seized without the proper court order may be excluded at trial, since it will have been seized illegally.

If none of these steps works, the program must permit the police to enter. Refusal to obey a direct order of the police may be a crime, even if the police are wrong, and forcible resistance would be unwise. If the program has made a good faith effort to convince the law enforcement authorities to pursue the proper route, it is unlikely that it would be held liable for allowing entry when argument fails.

Conclusion

Programs should develop protocols for dealing with the constellation of legal issues that may arise during the treatment of victims—or perpetrators—of domestic abuse. Programs should have a copy of the Federal regulations available at all times to show law enforcement officials and establish a relationship with an attorney who can be called upon to help in these situations. Finally, programs should reach out to law enforcement agencies before a crisis arises and work with them to develop ways of dealing with these kinds of issues. If the regulations are explained when there is no emergency and there can be no suspicion that the program is hiding anyone or anything, and a protocol is established, unpleasant confrontations may be avoided.

6 Linkages: A Coordinated Community Response

Isolation is a salient characteristic of domestic violence: It occurs in isolation and it isolates its victims from community life. Countering this pervasive isolation with a coordinated community response is perhaps the strongest way to eliminate domestic violence from our society (Clark et al., 1996). "If we are ever to eradicate domestic violence, the whole community must become alerted to the problem and how best to support the victims and convey to the abusers that abuse is a crime that is never justified" (Zorza, 1995a, p. 54).

Although the primary focus of this Treatment Improvement Protocol is on linking substance abuse treatment and domestic violence support services, the linkages cannot stop there: Other efforts to link and integrate community resources are essential—not only to ensure that the needs of individual survivors and batterers are met but also to raise public awareness and to begin to create the coordinated community response that is necessary for change. Coordinated intervention is crucial. These efforts must address needs for housing, child care, emotional and physical safety, health and mental health care, economic stability, legal protection, vocational and educational services, parenting training, and support and peer counseling, among others.

Linkages will also help each agency fulfill its own mission. Few programs have the resources available to address the sometimes overwhelming number of problems faced by substance abuse treatment clients who are affected by domestic violence. Increasingly, programs are looking to strong collaboration and linkages with other service agencies to meet their clients' needs. Such collaboration is particularly important in isolated rural communities where lack of resources and distance from services are significant problems.

In all communities—urban, rural, and suburban—individuals who provide substance abuse and domestic violence services in the public sector generally have experienced the negative consequences of fragmented and unintegrated service systems. Historically, their resourcefulness in obtaining necessary care for their clients has created an informal system of referrals and unofficial case management. Such linkages are becoming more formalized as system administrators realize the cost-effectiveness of collaboration and coordination of services and as public sector purchasers of Medicaid managed care become more sophisticated in contracting with managed behavioral health care organizations to ensure a continuum of services for clients served in the public sector.

Thus the current behavioral health care environment may be one especially open to change in the direction of linkages, collaboration, coordination, and service integration. This chapter calls on providers to be especially positive and creative in thinking about these issues and designing action plans. Those who have seen past efforts at service integration fail, who are skeptical about structural change within State service delivery systems, and who may be ambivalent about giving up turf are encouraged to support coordination and collaboration—that is, separate agencies planning together and working together to create new delivery approaches with support at the State level. This chapter focuses on two approaches to building linkages, the first based on systemic reform and the second rooted in the community. Two crucial linkages are highlighted—that between substance abuse treatment and domestic violence support services and that between these services and the criminal justice system.

Systemic Reform

Linkages are frequently conceived of as local program-to-program relationships, and much of the remainder of this chapter is devoted to such linkages. While not disputing the importance of community-based interagency networking, the Consensus Panel believes that a new way of thinking about linkages on the systems level can help address the multiple social service needs of substance-abusing victims and perpetrators of violence. In calling for substantive, top-down reform, the Panel allies itself with those domestic violence experts (Hart, 1995b; Hart et al., 1995) and mental health experts (Stroul, 1993) advocating a new approach to organizing and institutionalizing coordinated social service delivery systems.

Under this new paradigm, the familiar concept of a "continuum of services" is elevated to the State level and substantially expanded to include a formal structure and process to oversee system-level coordination among agencies. While specific goals would vary from State to State, the Panel believes that such systemic reform would enable States to create a collaborative infrastructure that, in turn, would allow programs to deliver care that is

- Client-centered—focused on meeting clients "where they are" and matching their needs with appropriate services as opposed to fitting clients into a predefined program; wraparound services follow the client
- Holistic—offering comprehensive services from a variety of agencies that are designed to respond to a client's multiple needs: substance abuse treatment, mental health counseling, domestic violence support, parenting skills training, housing
- Flexible—the service mix changes as the client's needs change
- Collaborative—multiple agencies can work together freely on behalf of a client without having to consider agency funding or other administrative issues that may interfere with the assistance process
- Coordinated—individualized service plans are developed for each client and monitored via case management
- Accountable—encourages the client's input to the comprehensive treatment plan, adheres to standards or accepted best practices for treatment, establishes and tracks qualitative and quantitative outcome measures, and evaluates services on the basis of client and community satisfaction.

Currently, most social services—including substance abuse treatment and domestic violence support—function as a series of parallel programs with their own sources of funding, leadership, and constituencies (Hart, 1995b; Hart et al., 1995; Stroul, 1993). Clients needing services from more than one program not only face a number of hurdles (e.g., differing eligibility requirements, hours of operation, and locations), but may also receive services that are counterproductive because they are not part of a coordinated treatment plan (Hart, 1995b).

In the environment that would emerge after converting from parallel services to an integrated delivery system, cooperation on the client's behalf would replace competition for the client and for the attendant funding that follows admission to a specific program or to a treatment slot or bed. Collaboration would eliminate duplication of services and receipt of inappropriate services. With a client-centered philosophy prevailing, the provision of adjunctive support services like child care, transportation, and housing would assume greater importance and would more likely be funded (Stroul, 1993).

Systemic reform on this scale requires structural, administrative changes at the State level. As a first step toward revamping service delivery to multiple-needs clients, the Panel envisions a mechanism that would

- Coordinate planning among disparate agencies based on client and community needs assessments
- Devise financing strategies that would allow for blended funding and strive for equitable allocation of resources among agencies
- Establish a vehicle for resolving any problems that emerge in the course of providing integrated services (e.g., development of compatible management information systems, cross-training, and support and authority for case management).

In its assessment of systems of care for children (Stroul, 1993), Georgetown University's Child Development Center discovered that, as expected, integrated systems of care expanded access to services, including adjunctive support, and increased the use of case management to monitor service delivery and advocate for individual clients and their families. The study also found that this approach, in some instances, reduced costs. For example, tnree counties in California saved more than $35 million over 4 years for residential care by using a systems model of service delivery. Similarly, Fort Bragg, North Carolina, reduced the costs of caring for children with serious emotional disturbances by 51 percent through the systems of care approach. The State of Kentucky likewise reduced the cost of services from $13.5 million to $9.5 million (Stroul, 1993).

Although these models have yet to be applied to the substance abuse and domestic violence fields, the Consensus Panel believes they hold promise for redefining the existing service delivery system to ensure more appropriate and effective care for substance-abusing domestic violence victims and perpetrators. The Panel strongly recommends that Federal and State policymakers consider a series of demonstrations designed to test the feasibility of changing the current system to institutionalize a formal administrative structure for promoting and supporting collaboration and linkages among social service programs.

Community-Based Linkages

The health care environment is increasingly forced to respond to the demand for cost containment; therefore, undertaking collaborative endeavors is critical to the future of many programs, especially at the community level. As noted, few have the resources to offer under one roof all the specialty services that clients need. Creative linkages can supplement and complement programs, building on their strengths and compensating for their weaknesses. Linkages can open avenues to diverse sources of funding to offset the inevitable ebb and flow of resources. And in a practical vein, a growing number of funding sources are granting funds *only when presented with evidence of coordinated activities among grant applicants.*

Community Assessment

Before linkages can be developed, it is necessary to know what resources exist within the community. Each entity has its own organization and its own culture that must be understood for collaboration to be successful. Every State has a unique infrastructure for housing the health care, legal, social, and other services related to substance abuse treatment and domestic violence services. Communities themselves also vary in government structure, available resources, and funding streams. Some combine alcohol treatment with treatment for other substance abuse, whereas others separate the two. Some locate services for victims of domestic violence in the criminal justice system, which affects the tone and procedures used to deliver services, while others locate such services in a hospital system linked to the emergency department. A program within a nonprofit entity in the private sector has far different restraints than one housed in a government agency.

Disciplines also differ dramatically in structure and orientation. Some substance abuse treatment programs, for example, are staffed by nurses, and others are staffed by certified addiction counselors. Many existing programs, such as Minnesota's Turning Point and African American Services, have incorporated family violence issues into substance abuse treatment, and communities throughout the United States are increasingly integrating the two areas (Clark et al., 1996). A single treatment approach would be enhanced by making programs accountable to the local community, strengthening the linkages between the two fields and the court system, and improving evaluation procedures.

The Argument for Case Management

In the current early state of development of linkages between the fields of substance abuse treatment and domestic violence services, it has been suggested that "the linkage mechanism that seems most appropriate is case management" (Collins et al., 1997, p. 400). Increasingly, the substance abuse treatment field has recognized that case management may be a key contributor to successful treatment (Ridgely and Willenbring, 1992). In the case management approach, a specially trained single practitioner or case management team is responsible for coordinating linkages to the wide variety of services—including domestic violence support—needed by many if not most clients in substance abuse treatment (Sullivan, 1994).

Although locating and gaining initial access to these services can be challenging, many programs have found that use of case management is well worth the effort, since it helps clients work through problems that may trigger use of alcohol and other drugs or that interfere with progress in treatment. Such problems may include homelessness, mental illness, HIV infection, lack of vocational skills, and unemployment (Willenbring, 1994). An additional advantage is that the case manager serves as a client advocate, representing the client's interests in both accessing other agencies and ensuring that their services are used effectively (Rapp et al., 1994).

Linking Substance Abuse Treatment and Domestic Violence Services

Several locales have attempted to develop model programs integrating substance abuse and domestic violence services. These include the Amend Program in several Colorado communities (Rogan, 1985–1986), the Intercede Program of Longford Health Sources in Ohio (Burkins, 1995), and the Pittsburgh Veterans Affairs Medical Center (Gondolf, 1995). A study of linkage efforts in Illinois found that staff cross-training is inadequate to meet the goals of these efforts (Bennett and Lawson, 1994).

This TIP takes some of the first steps in formalizing linkages between the two fields. Chapters 2 and 3 present substance abuse treatment providers, who may lack knowledge about this population, with psychosocial profiles of survivors and batterers and their needs for specialized care. Such training is a key ingredient in bringing the two fields closer. Chapter 4 stresses the need for screening for domestic violence early in the substance abuse treatment process and the importance of timely referral of clients affected by domestic violence to the appropriate agencies. Routine screening for cross-problems by both types of programs is a major step toward linkage.

Linkages With the Criminal Justice System

One of the first linkages that must be identified by a substance abuse treatment program that is working with domestic violence survivors is with the legal system (see Chapter 5). A legal professional or legal service is the best resource for resolving problems that pertain to individual clients' involvement in the justice system and may be the best resource for information and guidance regarding the Violence Against Women Act (VAWA). Many of the Act's provisions—such as those relevant to immigrants—are complex and detailed. In addition, other Federal and State statutes may include provisions that appear to contradict those of the VAWA.

To treat substance abuse clients who are either survivors or batterers, treatment providers must be knowledgeable about policies and laws related to domestic violence; they must understand the roles of police, judges, probation staff, and other representatives of the justice system and be able to interact effectively with these individuals when necessary. As one field reviewer noted, "Integrating the criminal justice system's efforts should be the first step in forming linkages. If a provider wants assistance protecting a woman or getting a batterer to attend treatment, it is the criminal justice system that can get this done."

Specialized courts to process domestic violence cases, which combine intensive survivor services, treatment for batterers, and an active judicial role in the social contexts of the community, have been established. The Dade County, Florida, Domestic Violence Court, which commenced in late 1992, is a noteworthy example, and outcomes are still being evaluated (Fagan, 1996). However, some early data indicate that recidivism rates among treated batterers processed through these courts are high and comparable to rates found in studies of the deterrent effects of protective orders and arrests. Failure rates are strongly correlated with lengthy prior records and a history of abuse in the batterer's family of origin (Fagan, 1996).

In pursuing victim protection goals, criminal justice agencies have been required to expand their traditional focus on the detection and punishment of crimes. Placing these expectations on police and prosecutors may require tasks and roles for which they are not well trained. Such role and policy ambiguities can affect the performance of agencies with respect to their missions. As Fagan notes:

> There is no doubt that linkages between legal institutions and services for domestic violence victims are critical to stopping violence. However, these linkages may best be accomplished through a strategic division of roles among institutions that tap the strengths of each organization. . . . Although legal systems should be open and accessible to battered women, these institutions should not take on the role of managing the coordination of services that involve social service, shelter, and other interventions. (Fagan, 1996, pp. 39–40)

Collaborative Treatment Planning For Survivors and Batterers

Treatment plans for substance abuse clients who are survivors or batterers must incorporate all the issues surrounding both sets of problems and ideally will be coordinated by a case manager. Treatment planning for matters such as time sequencing (e.g., when to start support for a domestic violence survivor in substance abuse treatment) and goals of treatment is not effective without consideration of all the factors that have a bearing on the client's best interests. Substance abuse treatment providers, domestic violence experts, and legal or other relevant professionals should plan treatment collaboratively.

Because treatment plans for domestic violence survivors are built around the premise that safety must always be the first priority, substance abuse treatment may initially take a back seat. For example, a client who lives with a violent partner may report being pressured or coerced by him to use alcohol or other drugs. In these instances, some degree of relapse may need to be tolerated in light of the threat to the client's safety. A survivor's frequent reporting of such a situation, however, signals the need for substance abuse treatment and domestic violence staff to jointly reconsider treatment priorities.

A batterer entering treatment for substance abuse can be required to sign a contract agreeing, among other stipulations, to refrain from using violence (see Chapter 4). Such "no-violence contracts" are most effective when linkages are made with other agencies involved with his case, and violations should be reported to all involved agencies, especially the criminal justice system.

Treatment providers can help persuade the courts to consider alternative sanctions that take the victim's circumstances into account. Incarcerating batterers can actually harm their victims by taking away the family income. On the other hand, not incarcerating the batterer may give him the false message that his behavior is not that bad and thus tacitly give him "permission" to continue his violence. Courts may order the batterer to receive counseling, perform public service, or a variety of other sanctions.

Identifying Critical Linkages, Barriers, And Opportunities

Figure 6-1 highlights some of the key linkages substance abuse programs should consider in developing collaborative strategies to assist clients with domestic violence problems. Some duplication across the lists is intentional.

Figure 6-2 lists some of the potential obstacles to forming collaborative relationships between substance abuse treatment and domestic violence programs, as well as opportunities for collaboration and ideas for taking action to form such relationships.

Establishing a Linkage Relationship

All relationships begin with a "getting-to-know-you" phase; initial, face-to-face interactions often establish the tone for future interaction. These initial meetings should include a discussion of the origins of both communities in order to help each understand the other's beliefs and attitudes. Other topics for discussion include each program's goals for its clients, the barriers routinely faced with clients, typical interactions with clients, and expected outcomes. Key individuals in each system can coach the staff of the other in working with and understanding that system and the needs of its clients. During the initial phase, it also may be helpful to acknowledge some of the stereotypes held by each field about the other and to discuss them frankly.

Figure 6-1

Key Linkages

Health Care

- Screening for Child Abuse and Neglect (SCAN) teams in hospital emergency rooms
- Health administrators
- Veterans health care systems
- Primary care physicians
- Obstetricians/gynecologists
- Pediatricians
- Nurses and nurses assistants
- Midwives
- Nurse practitioners in adult, obstetrician/gynecologist, and pediatric settings
- Physician assistants
- Public health workers
- Dentists
- Emergency medical technicians
- Medical social workers
- Home health services
- Forensic examiners
- Plastic and maxillofacial surgeons
- Physical, speech, and occupational therapists
- Health educators
- Wellness groups
- Women, Infants, and Children (WIC) Supplemental Food Program specialists
- Alternative medicine practitioners
- Health care programs (e.g., infant mortality reduction programs, HIV/AIDS programs, and tuberculosis programs)

Justice System

It is important to understand the operations of the court system in your jurisdiction and to identify the judges who oversee

- Drug cases
- Driving Under the Influence (DUI) and Driving While Intoxicated (DWI) infractions
- Child abuse and child neglect cases
- Domestic violence violations
- Custody cases
- It is also useful to identify experts in the following offices and programs:
- Probation and parole
- Legal Aid
- District Attorney's office
- Family courts
- Specialty units of attorneys (e.g., for child abuse and neglect and family violence)
- Jails and prisons
- Bail bondsmen
- Law enforcement (all levels, e.g., sheriffs and police)
- Pretrial release agencies
- Public defenders
- Divorce attorneys
- Pro bono attorneys
- Juvenile detention facilities
- Victim assistance programs
- Appropriate section of the local Bar Association

Education/Schools

- School boards
- School administrators
- Teachers
- Teaching assistants
- School counselors
- School social workers
- School nurses
- General equivalency diploma (GED) specialists
- Head Start and child care specialists

Figure 6-1 (continued)

Education/Schools (continued)

- Vocational education and training counselors
- Guidance counselors
- Special education specialists (emotional and physical problems)
- Early intervention specialists
- School psychologists
- Physical education teachers and coaches
- Prevention specialists
- Parent–teacher organizations (PTOs)
- English as a Second Language (ESL) classes
- Literacy volunteers

Adult Education

- Night schools
- Community colleges
- Senior day care centers
- Native-American centers
- Hispanic-American centers
- Asian-American centers

Employers

- Employee Assistance Programs (EAPs)
- Human resource administrators
- Foundation administrators
- On-the-job counselors and social workers

Social Welfare

- Foster care (family foster care, relative foster care, and residential foster care, including group homes)
- Social welfare administrators
- Social workers
- Temporary Assistance to Needy Families
- Welfare-to-work programs
- Food stamp programs
- WIC
- Child protective services
- Adult protective services (especially for elderly persons)
- Head Start
- Income maintenance
- Child care programs
- Transportation subsidy programs
- Community-based child abuse and neglect prevention services and programs
- Hotlines
- Family support programs
- Community-based family agencies (provide parent education and specialized counseling for children at low or no cost)
- Family preservation programs
- Homeless shelters
- Maternal and child health programs
- Women's programs

Domestic Violence

- Hotlines
- Shelters
- Child care workers and child advocates
- Programs for children in violent families
- Transitional living (homeless) experts
- Clinicians, public and private (e.g., therapists)
- Programs for batterers
- Legal advocacy systems
- Visitation centers for children
- Support groups
- Surveillance systems
- Abuse and assault hotlines
- Rape crisis programs

Figure 6-1 (continued)

Domestic Violence (continued)

- Victim services
- Model programs offering specialized services for sexually abused children
- College-based date rape programs
- Survivor support groups
- Forensic nurse examiners

Mental Health

- Clinicians (e.g., psychiatrists, social workers, psychologists, and psychiatric nurses)
- Child guidance centers
- Mental hospitals and institutions
- Community-based activity centers for deinstitutionalized persons
- Group homes and halfway houses
- Hotlines and crisis centers
- Hospital inpatient units
- Hospital outpatient services
- Community mental health centers
- Outpatient day services (community mental health day hospitals)

Substance Abuse

- Residential or inpatient detoxification programs, intensive residential programs, and therapeutic community programs and services (private, public, and combined)
- Outpatient drug-free, methadone maintenance, and partial-day programs and services (private, public, and combined)
- Self-help groups (e.g., Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, and Rational Recovery)
- Al-Anon (support groups for families of substance abusers)
- Prison- or jail-based substance abuse programs
- DUI and DWI programs
- Veterans Affairs substance abuse treatment programs
- Special programs for adolescents, children, and families
- Special treatment programs for pregnant women or women with dependent children
- Halfway houses, recovery homes
- Alcohol and drug prevention programs
- Community-based coalitions for the prevention of substance abuse
- EAPs (government and private)

Other Community Resources

- Governmental and regulatory agencies
- Funding sources
- Religious institutions (e.g., churches and synagogues)
- Community housing programs
- Recreation programs
- Neighborhood watch associations
- Immigrant services
- Child care programs
- Transportation programs for persons with developmental and physical disabilities
- Support groups (e.g., Grandparents as Parents)
- Fathers' responsibility projects
- Nutritional centers, food banks
- Senior citizens' agencies
- Travelers Aid

Figure 6-2

Facets of Collaboration Between Substance Abuse Treatment and Domestic Violence Programs

Perceptions and Attitudes of Those Working in the Field

■ **Barriers**	Stereotypes, generalizations, and myths about the other field
■ **Opportunities**	Special joint conferences to explore common ground and bridge gaps
■ **Action Ideas**	Develop cross-training courses for providers in network through community college or other sources
	Exchange agency newsletters
	Serve on one another's board of directors
	Arrange continuing education unit credits for participants

Funding and Reimbursement

■ **Barriers**	Limitations on reimbursable services, particularly under managed care
	Limitations imposed by the terms of funded research, which may constrain the program's ability to provide needed services
■ **Opportunities**	Work with State Director to incorporate language in managed care contracts to support needed services
	Identify other funding sources more amenable to services being offered and seek funding for specific program components
■ **Action Ideas**	Learn about blended funding strategies
	Adjust program accounting system to receive and account for blended funds
	Track outcomes of clients receiving services from linkage partners and document their outcomes for research and funding entities; use results to secure additional funding

Welfare Reform

■ **Barriers**	Increased limits on shelter stays
■ **Opportunities**	Increased funding of collaborative and innovative programming
■ **Action Ideas**	For example, in Wisconsin, the Milwaukee Women's Center has developed a collaboration between employment maintenance organizations, health maintenance organizations, and community-based organizations to establish specialized services for survivors who are substance abusers

Fundraising

■ **Barriers**	Limited availability of funds from any source
■ **Opportunities**	Identify appropriate partners for funding opportunities and lay groundwork for response to funding opportunities
	Identifying funding sources is in and of itself an incentive to establish linkages

Figure 6-2 (continued)

■ **Action Ideas**	Partner with a proven "fundraiser" to supply a needed specialized service (e.g., via subcontract)
	Send interested staff to grant-writing workshops
	Through board/community contacts, identify an advocate who will introduce the program to potential funders
	Identify a volunteer who will review the CBD and other resources for Requests for Proposals (RFPs) and Requests for Applications (RFAs)
	Publicize positive program results continually
	Convene a meeting with local funders and discuss the feasibility of encouraging joint applications between domestic violence and substance abuse providers

Sociopolitical Issues

■ **Barriers**	Prevailing political climate, which does not readily offer support for treatment programs
	Relative newness of both fields and their lack of history, which does not easily allow documentation of success
	Lack of social acceptance for both programs
	Perception of domestic violence as a "woman's field," in contrast to the perception of politics as a "man's world"
■ **Opportunities**	Grassroots-level recognition of the overlap of the problems of substance abuse and domestic violence
	Research and evaluation to document the effectiveness of both efforts in ways that are understood by policymakers
■ **Action Ideas**	Form political action coalitions

Programmatic, Staffing, and Logistical Concerns

■ **Barriers**	Wide variety of different agencies and agendas with which programs must work
	Growing push for higher credentials
■ **Opportunities**	Expanded roles of counselors and other professionals in each field; increased respectability and acceptance of these fields
■ **Action Ideas**	Work with the National Association of Alcohol and Drug Abuse Counselors to explore this issue fully and investigate credentialing implications
	Seek legitimacy for staff skills through courses developed and offered by recognized bodies (e.g., colleges and associations)

Recordkeeping and Data Management

■ **Barriers**	Increasing need for employees to have computer skills and for organizations to have access to on-line and other technological resources
■ **Opportunities**	Increased information available for staff to use
	Increased ability to provide documentation of successes
■ **Action Ideas**	Joint training, leadership programs, staff and materials exchange, information and evaluation exchange

Figure 6-2 (continued)

Relationship With the Criminal Justice System

■ **Barriers**	Competing need for information Therapeutic alliance versus prosecution's adversarial need for information
■ **Opportunities**	Develop boundaries and administrative/therapeutic splits to protect information being used for treatment from information related to behaviors and actions

Relationship Between Workplace and Treatment

■ **Barriers**	Identification of domestic violence problems can have adverse impact on career no matter what the resolution of the case
■ **Opportunities**	Develop a problem-based definition of abuse that is linked to behavioral goals

At these initial meetings, using a staff member with strong facilitation skills can be invaluable. An alternative is to use a facilitator from an outside agency not affiliated with either program (e.g., from a university or community college). The facilitator can recognize burgeoning problems and defuse them before group members become defensive and uncooperative, and he or she can help participants bridge gaps in understanding by clarifying terminology and asking for feedback to ensure that all parties are interpreting information the same way. A followup memo documenting the understandings that emerged from the meeting and listing areas of agreed-upon responsibility can also assist the collaborative process.

Airing and Addressing Grievances

In collaborative relationships, difficulties can arise if one entity feels taken advantage of, perceives that the other is deriving more benefits from the association, receives more credit, or believes that power is unequal between the two groups. Balance is central to an effective collaboration that satisfies the expectations and needs of all involved. When a collaborative domestic violence effort, for example, used the letterhead of one participating organization, the other partners were displeased because their participation was not acknowledged. To give equal recognition to all partners, a new project-specific letterhead reflecting all the collaborators was designed. Not all solutions will be so simple, but this example demonstrates the importance of frank communication, responding to the concerns of all the partners in the network, and moving quickly to resolve problems.

Readiness for Collaboration: Program Evaluation

Many programs have in place a system for periodic internal evaluation of their success in meeting their goals. Decisionmakers may find it useful to reexamine a program or organization specifically in terms of its readiness to take advantage of and maintain a collaborative association.

Staff roles

For successful linkages, program staff—beginning with boards of directors—must be sensitive to the other program's requirements and culture. A board that consists of members who are committed to supporting program goals and overcoming challenges is essential to effective operation. Motivated and well-connected directors can, for example, help identify community funding sources that will support the development of collaborations.

Administrators can promote linkages by identifying conflicts or economies of scale in the areas of fiscal management, accounting, contract management, funding development, program evaluation and organizational audits, human resources and payroll management, management information systems, and other technology. They can also enhance linkages and develop funding sources by working with other agencies and programs to compete for block grant funds and to split funding for substance abuse and domestic violence. Program managers should appoint a staff member as a contact and liaison for each linkage. Administrators and managers should seek to create an organizational environment that encourages and supports staff members' collaboration activities, which are often time-consuming. Staff members' new collaborative relationships, as well as their existing relationships with other agencies, are critical to success.

Cultural competence

Substance abuse treatment and domestic violence professionals also must educate themselves on issues particular to each cultural or ethnic subgroup their clients represent. Failure to do so diminishes outcomes and completion rates for minority populations. Cultural competence is more important than ever now, as the country moves toward a "majority-less" ethnic composition and major cities become pluralities of cultures rather than majority-minority paradigms. Responding to the needs of clients will require an awareness of practice and attitude and an organizational structure that continually monitors:

- How are services provided to diverse groups?
- What is the environment in which services are offered?
- What is the composition of the group?
- How included do diverse clients feel during the treatment process, and what cultural activities are directed to a specific population?
- How can treatment be tailored to a particular group?
- Are there staff members who know the language of non-English-speaking clients?
- What networks have been created with other experts and members of the community to provide services to this population?

Lastly, cultural competence implies that agencies are equipped to respond to "insensitivity" and that they make inclusiveness an institutionalized value, in part by employing highly skilled multicultural staff (Cross et al., 1989).

The critical role of evaluation

Evaluation helps programs measure how effective they are in achieving their goals and gives them information to redesign and improve program components. Increasingly, funding sources require documentation of the program's success and of individual outcomes. However, in the fields of substance abuse treatment and domestic violence, outcomes may not always be as clear-cut or as measurable as funders would like. Administrators must be aware that a funding source or other outsider to the field may not agree with or approve of a program's criteria for success. For example, relapse is an expected part of recovery from substance abuse, and abstinence may not be the sole indicator of treatment success. Treatment effectiveness should also be measured by larger social indicators, such as higher employment rates, better personal relationships, and fewer legal entanglements (Wolk et al., 1994). After treatment, some people will not be drug-free for the rest of their lives, but they will experience more stability and more productive lives, resulting in significant benefits to society.

Understanding the True Costs of Collaboration

Even if an organization takes all the steps above, the path to collaboration is still paved with unforeseen difficulties. The importance of differences in perspectives between the two fields, as discussed in Chapter 1, should not be underestimated. One survey of staff in both types of program found that more than half of all staff cited "conflicting beliefs about personal responsibility" as a reason for noncooperation between programs (Bennett and Lawson, 1994). Service delivery structure and funding also can block collaboration.

Furthermore, confidentiality and informed-consent practices vary among fields (see Appendix B). Large programs may have trouble linking with small programs, especially if documentation and tracking procedures are incompatible. Conversely, small grassroots programs may have problems following the formal procedures required by larger organizations or may lack staff to ensure that paperwork is completed in a timely fashion. Professionally led and staffed organizations may doubt the competence of paraprofessional staff members who are in recovery and may discount their suggestions in the course of treatment planning. Similarly, untrained staff may fail to recognize the validity of the insights and suggestions proffered by professional social work and mental health care givers.

Other issues affecting the costs of collaboration include the number of approvals and layers of bureaucracy that must be negotiated to obtain services from a linked agency, requirements for research and evaluation that may be attached to participation in a network, and the amount of staff time required to maintain linkages and resolve problems.

Other Linkage Strategies

Funding Sources and Reimbursement

Funding sources for domestic violence support include the criminal justice system through Federal block grants, State money, or fines levied against perpetrators. Private and community organizations also represent funding sources. Employee assistance programs (EAPs) can serve as both allies and access points to solicit and obtain corporate funding. Third party reimbursement for domestic violence services is slowly gaining some acceptance. At one time, insurers might have refused to pay for these services for a woman who was covered under the batterer's policy, reasoning that the woman's injury was self-inflicted because she chose to stay with the batterer. In some cases, the batterer must authorize payment for treatment for the survivor if medical, health, or disability coverage is in his name.

One reason domestic violence has not been incorporated into concepts of managed care is that, as discussed in Chapter 1, some advocates for domestic violence survivors have rejected the use of a medical model to define the problem. In addition, most managed care companies have specific requirements about who can deliver services; if no program staff meet those requirements, it is not likely that the program will be reimbursed. Domestic violence support encompasses services such as housing and job training that are outside the realm of health care and that have outcomes difficult to measure in terms of health improvement, which are the outcomes of interest to health maintenance organizations (HMOs). However, many managed care organizations are investing funds to help their enrollees deal with issues that are not traditionally medical; many HMOs offer strss management and exercise programs. All health systems are increasingly recognizing the cost-effectiveness of early detection and prevention in general in their covered populations, and some have set up routine screening for substance abuse. Furthermore, increased interest in outcomes measurement and consumer satisfaction has broadened the spectrum of behaviors monitored and outcomes measured by health care providers.

Reimbursement from managed care organizations and other third parties relies on diagnostic classifications and treatment categories. Advocates for reforms in health care and social welfare must find ways to classify joint substance abuse–domestic violence problems to ensure reimbursement. Although some domestic violence programs use the classification "trauma" and receive reimbursement for treatment, services are frequently provided as nonreimbursable advocacy or coaching. Victims who are thought to have underlying problems are typically referred to other programs (e.g., for psychological or substance abuse treatment). Research indicates that there are no psychological risk markers for becoming a victim of adult domestic violence (Hotaling and Sugarman, 1990). However, certain characteristic symptoms are seen in many people following highly traumatic life events. Some battered women experience these symptoms as a result of violence-associated trauma, and they are normal psychological responses to stressful life events. Often, these symptoms dissipate as women achieve greater safety from the abuse. Other women may require more intensive therapeutic interventions to heal from the effects of violence. The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders*, Fourth Edition (DSM-IV) (American Psychiatric Association, 1994), offers some diagnoses that may be helpful in classifying survivors' symptoms and helping programs receive reimbursement for treatment. Some survivors may meet criteria for posttraumatic stress disorder (see Chapter 2) or for depressive and anxiety disorders.

Licensing, Credentialing, And Certification

Credentialing processes for substance abuse treatment providers must assess their ability to screen for violence and create a safety plan, as well as their knowledge of legal issues related to domestic violence. They should demonstrate a knowledge of child abuse and neglect, child sexual abuse, partner violence, elder abuse, extended family violence, and violence as an issue in relationships other than marital or partner relationships.

Examples of Effective Community-Based Linkages

In Bismarck, North Dakota, the Federation of Family Funding promoted and supported the development of a multiagency partnership plan to help families experiencing domestic violence. All providers involved with the family meet face-to-face every month to share information, make plans, and discuss strategies for ensuring progress. In a Los Angeles program for pregnant or substance-abusing battered mothers, a team of providers involved in all aspects of a client's treatment meets as a group with the client. Children's grandmothers, if they are the formal court-appointed caretakers of the children, are included in the case conferences; perpetrator fathers are not. Interagency agreements are made in advance to protect confidentiality.

Examples in Health Care Settings

Many of the linkages between domestic violence support services and other service organizations that have been most effective have occurred in health care settings, especially in hospitals. Linkages of the type described here might benefit from involvement of staff from substance abuse treatment programs. At the Dekalb Medical Center in Atlanta, emergency room nurses who suspect that a woman has been battered call a patient representative with specialized knowledge to interview the patient after medical treatment is provided (Dekalb Medical Center, 1993). The representative, who is able to spend more time with the patient than the nurses, refers the patient to a community shelter or makes other referrals and also provides feedback to the emergency room staff.

Other examples of hospital-based service linkages come from Boston, Minneapolis, and Seattle (Loring and Smith, 1994). At Children's Hospital in Boston, staff from AWAKE, an advocacy program for battered women and their children, are called in to provide safety planning and support for patients who are violence survivors. In Minneapolis at the Hennepin County Medical Center, an advocate from a battered women's shelter makes rounds in all services—not just the emergency room—to speak directly with medical staff and interview violence survivors. In this way the hospital administration and medical staff are assured that in addition to receiving appropriate medical care, survivors are assisted in other areas, such as locating the batterer, obtaining legal protection, and proceeding with assault charges when appropriate. Harborview Hospital in Seattle employs an "adult abuse protocol" with components of various systems to ensure comprehensive services to the battered woman patient. Finally, health maintenance organizations, many of which maintain detailed databases to track service utilization and outcomes, may find it easier than general hospital systems to identify and reach out to survivors of domestic violence.

Promising Activities and Future Directions

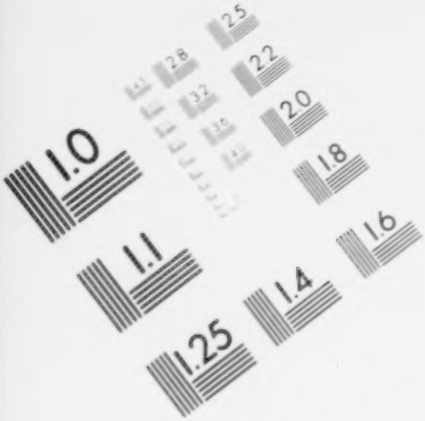
In 1994 the Board on Children and Families, the National Research Council, and the Institute of Medicine sponsored a 3-day workshop, Violence and the American Family (Chalk, 1994). Although the focus was a broad one and included child and elder abuse as well as other forms of family violence, many of the participants suggested action ideas for linkages among agencies involved in the treatment of domestic violence survivors and batterers. As can be readily seen, no single agency or system can successfully undertake the broad tasks and initiatives outlined below that were suggested by workshop participants. Rather these projects invite broad collaboration and cooperation.

In the area of *social services*, tasks to be undertaken included (Chalk, 1994)

- Developing a set of principles for designing violence interventions that would ensure client empowerment, build on family strengths, and be based on effectiveness evaluations
- Creating violence intervention and prevention systems at the community level that build on formal and informal social networks in diverse neighborhoods
- Requiring schools to make violence prevention education mandatory
- Exploring new methods of cash payments to families to deter violence resulting from economic stress.

In the area of *health*, the workshop participants identified three specific initiatives (Chalk, 1994):

- A national campaign against violence to focus on health aspects and costs of family violence to society
- Improvement of screening and diagnosis among health and mental health professionals of risks and injuries associated with family violence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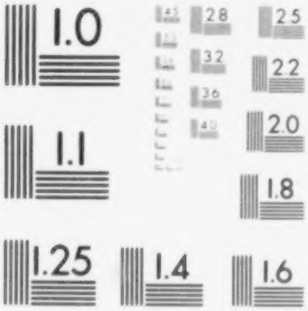
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- Consensus-building about what is known about family violence, leading to the formation of a constituency to serve as an advocacy group to educate public officials.

In the area of *criminal justice*, three issues were raised as fruitful areas for activities (Chalk, 1994):

- Effectiveness research on the use and enforcement of restraining orders to deal with domestic violence; new methods of offender control, such as electronic monitoring may be effective
- Research on the availability and effectiveness of court-ordered treatment and on returning abusers to their families
- Consideration of new proposals that experiment with the development of a one-family, one-judge court system.

In addition to these recommendations, the workshop participants outlined three broad steps necessary to establish a much-needed basis for future research and program plans (Chalk, 1994):

- Develop a broad-based public education campaign to foster understanding of family violence
- Bridge the gap between research resources and policy needs, especially by developing rigorous evaluations of public sector programs to reduce domestic violence
- Integrate preventive measures for domestic violence into a comprehensive, community-based program of family support services across a spectrum of developmental milestones. The goal goes beyond information sharing and seeks to simplify access to services.

A Public Health Approach

A public health approach has been effective in reducing morbidity and mortality by modifying behavior in many areas (e.g., campaigns to reduce smoking, to reduce alcohol abuse among pregnant women, and to prevent head injuries by wearing helmets). A public health approach to violence has been suggested (Koop and Lundberg, 1992) in response to the surge in morbidity and mortality due to violence (Prothrow-Stith, 1991). As the epidemiological evidence mounts that society's rising mortality figures are due in large part to violence, public health professionals acknowledge the destruction of "quality years of life" as well as the expensive healing process and now study the problem in terms of understanding and changing unhealthy outcomes (Koop and Lundberg, 1992).

Public health officials, generally solution-driven rather than theory-driven, view domestic violence as the result of a complex array of causal factors. By focusing on "risk factors," they can identify structural, cultural, and situational conditions that accompany, precede, and follow events of interpersonal violence (Moore, 1995). They also monitor public health, identify at-risk groups, and implement programs with evaluation components.

Education is a critical component of a public health campaign. In Houston, for example, the March of Dimes targeted both health care professionals and the public with educational interventions and brochures about battering during pregnancy; public service announcements were developed for the media.

Coordination of Care

Though the examples above do not include substance abuse treatment as one of their linkages, they provide a blueprint for the coordination of care that the Consensus Panel recommends. While the Panel believes the current system of parallel services should be integrated at the State level, meaningful change can occur at the community level. For either substance abuse treatment or domestic violence support services to be successful, the two fields must pool their energies to address gaps in client services *outside* the immediate networks of substance abuse treatment and violence support. Enduring linkages with other agencies and programs must be established to supply those ancillary services essential for positive client outcomes.

Appendix A
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Appendix B
Federal Confidentiality Regulations

by Margaret K. Brooks, Esq.[1]

Federal law (United States Code, Title 42, §§290dd-2 [1992]) and the Federal regulations that implement it—Title 42, Part 2, of the *Code of Federal Regulations* (42 C.F.R. Part 2)—guarantee the strict confidentiality of information about all persons receiving substance abuse prevention and treatment services.[2] They are designed to protect privacy rights and thereby attract individuals into treatment. The regulations are more restrictive of communications than are those governing the doctor-client relationship or the attorney-client privilege. Violating the regulations is punishable by a fine of up to $500 for a first offense or up to $5,000 for each subsequent offense (§2.4).

While some persons may view the restrictions that Federal regulations place on communications as a hindrance, if not a barrier, to program goals, due foresight can eliminate most of the problems that arise from the regulations. Familiarity with the regulations will facilitate communication and minimize the incidence of confidentiality-related conflicts among program, client, and outside agencies.

Types of Programs Covered by the Regulations

Any program that specializes, in whole or in part, in providing treatment, counseling and assessment, and referral services, or a combination thereof, for clients with alcohol or other drug problems must comply with the Federal confidentiality regulations (§2.12(e)). It is the kind of services provided, not the label, that determines whether a program must comply with the Federal law. Calling itself a "prevention program" does not insulate a program that also offers treatment services from the need to comply with confidentiality regulations. Although the Federal regulations apply only to programs that receive Federal assistance, the word *assistance* is broadly interpreted and includes indirect forms of

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Federal aid such as tax-exempt status or State or local funding that is derived, in whole or in part, from the Federal government.

Federal Confidentiality Laws

The Federal confidentiality law and regulations protect any information about a client if the client has applied for or received any alcohol- or drug abuse-related services—including assessment, diagnosis, detoxification, counseling, group counseling, treatment, and referral for treatment—from a covered program.[3] The restrictions on disclosure apply to any information that would identify the client as a substance abuser, either directly or by implication. The rule applies from the moment the client makes an appointment. It applies to clients who are civilly or involuntarily committed, minors, clients who are mandated into treatment by the criminal justice system, and former clients. Finally, the rule applies whether or not the person making the inquiry already has the information, has other ways of getting it, enjoys official status, is authorized by State law, or comes armed with a subpoena or search warrant.[4]

Conditions Under Which Confidential Information May Be Shared

Information that is protected by the Federal confidentiality regulations may always be disclosed after the client has signed a proper consent form. If the client is a minor, parental consent must also be obtained in some States. The regulations also permit disclosure without the client's consent in several situations, including communicating information to medical personnel during a medical emergency or reporting child abuse to the authorities.

The most commonly used exception to the general rule prohibiting disclosures is for a program to obtain the client's consent. The regulations' requirements regarding consent are somewhat unusual and strict and must be carefully followed.

Items required for disclosure of information

Disclosures are permissible if a client has signed a valid consent form that has not expired or been revoked (§2.31). A proper consent form must be in writing and must contain each of the items that appear in Figure B-1.

A general medical release form, or any consent form that does not contain all of the elements listed in Figure B-1, is not acceptable. A sample consent form may be found in Figure B-2. Two of the required items in Figure B-1 merit further explanation: the purpose of the disclosure and how much and what kind of information will be disclosed. These two items are closely related. All disclosures, especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need for or purpose of the disclosure (§2.13(a)). It would be improper to disclose everything in a client's file if the person making the request needed only one specific piece of information.

In completing a consent form, one must determine the purpose of or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed and to restrict the disclosure to what is essential to accomplish the identified need or purpose. As an illustration, if a client needs to have the fact that he or she has entered a treatment program verified in order to be eligible for a benefit program, the purpose of the disclosure would be "to verify treatment status," and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Jane Doe (the client) is receiving counseling at XYZ Program."

Figure B-1
Client Consent Form: Required Items*

- Name or general description of the program(s) making the disclosure
- Name or title of the individual or organization that will receive the disclosure
- Name of the client who is the subject of the disclosure
- Purpose of or need for the disclosure
- How much and what kind of information will be disclosed
- A statement that the client may revoke the consent at any time, except to the extent that the program has already acted in reliance on it
- Date, event or condition upon which the consent expires, if not previously revoked
- Signature of the client (and, for minors in some States, his or her parent)
- Date on which the consent is signed

*As set forth in §2.31(a).

The client's right to revoke consent

The client may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has made a disclosure prior to the revocation, the program has "acted in reliance" on the consent and is not required to try to retrieve the information it has already disclosed.

The regulations state that acting in reliance includes providing services in reliance on a consent form permitting disclosures to a third party payer. Thus, a program may bill the third party payer for past services to the client even after consent has been revoked. A program may not, however, make any disclosure to the third party payer in order to receive reimbursement for services provided after the client has revoked consent (§2.31(a)(8)).

Expiration of the consent form

The form must also contain a date, an event, or a condition on which it will expire, if not previously revoked. A consent must last "no longer than reasonably necessary to serve the purpose for which it is given" (§2.31(a)(9)). If the purpose of the disclosure is expected to be accomplished in 5 or 10 days, it is better to stipulate that amount of time rather than to request a longer period or have a uniform 60- or 90-day expiration date for all forms.

The consent form may specify an event or a condition for expiration, rather than a date. For example, if a client has been placed on probation on the condition that he or she attend the treatment program, the consent form should not expire until the expected time of completion of the probationary period. Alternatively, if a client is being referred by the program to a specialist for a single appointment, the consent form should say that consent will expire after he or she has seen "Dr. X," unless the client is expected to need ongoing consultation with the specialist.

Signatures of minors and parental consent

In order for a program to release information about a minor, even to his or her parent or guardian, the minor must have signed a consent form. The program must obtain the parent's signature to make a disclosure to anyone else only if it was required by State law to obtain parental permission before providing treatment to the minor (§2.14). (*Parent* includes parent, guardian, or other person legally responsible for the minor.) In other words, if State law does not require the program to get parental consent in order to provide services to a minor, parental consent is not required to make disclosures (§2.14(b)). If, by contrast, State law requires parental consent to provide services to minors, parental consent also is required to make any disclosures.

Figure B-2

Consent for the Release of Confidential Information

I, ____, authorize

(Name of client)

____

(Name or general designation of program making disclosure)

to disclose to ____

(Name of person or organization to which disclosure is to be made)

the following information: ____

____

____

(Nature of the information, as limited as possible)

The purpose of the disclosure authorized herein is to: ____________________________

____

____

(Purpose of disclosure, as specific as possible)

I understand that my records are protected under the Federal regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

____

(Specification of the date, event, or condition upon which this consent expires)

Dated: ________ ____

(Signature of participant)

____

(Signature of parent, guardian, or
authorized representative when required)

Required notice against redisclosing information

Once the consent form has been properly completed, one formal requirement remains. Any disclosure made with written client consent must be accompanied by a written statement that the information disclosed is protected by Federal law and that the recipient may not make any further disclosure unless permitted by the regulations (§2.32). This statement, not the consent form itself, should be delivered and explained to the recipient at the time of disclosure or earlier.

The prohibition on redisclosure is clear and strict. Those who receive the notice are prohibited from rereleasing information except as permitted by the regulations. A client may, of course, sign a consent form authorizing such a redisclosure. A sample Notice of Prohibition appears in Figure B-3.

Decisions Concerning Disclosure

The fact that a client has signed a proper consent form authorizing the release of information does not force a program to make the proposed disclosure, unless the program has also received a subpoena or court order (§§2.3(b); 2.61(a)(b)). The only obligation the program has is to refuse to honor a consent that is expired, deficient, or otherwise known to be revoked, false, or invalid (§2.31(c)).

In most cases, the decision whether or not to make a disclosure pursuant to a consent form is within the discretion of the program, unless State law requires or prohibits disclosure once consent is given. In general, it is best to follow this rule: Disclose only what is necessary, for only as long as is necessary, in light of the purpose of the communication.

Rules Governing Communication of Information

Seeking Information From Collateral and Referral Sources

Making inquiries of parents, other relatives, health care providers, employers, schools, or criminal justice agencies might seem at first glance to pose no risk to a client's right to confidentiality, particularly if the person or entity approached for information referred the client to treatment. Nonetheless, it does.

Figure B-3

Prohibition on Redisclosing Information Concerning Substance Abuse Treatment Clients

This notice accompanies a disclosure of information concerning a client in alcohol/drug abuse treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse client.

When a program that screens, assesses, or treats a client asks a relative or parent, a doctor, an employer, or a school to verify information it has obtained from the client, it is making a "client-identifying disclosure." *Client-identifying information* is information that identifies someone as a substance abuser. In other words, when program staff seek information from other sources, they are letting these sources know that the client has asked for treatment services. The Federal regulations generally prohibit this kind of disclosure, unless the client consents.

How should a program go about making such requests? The easiest way is to get the client's consent to contact the relative, doctor, employer, school, or health care facility. When filling out the consent form, staff should give thought to the "purpose of the disclosure" and "how much and what kind of information is to be disclosed." For example, if a program is assessing a client for treatment and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The "kind of information disclosed" would be limited to a statement that "Robert Roe (the client) is being assessed by the XYZ Program." No other information about Robert Roe would be released. If the program not only seeks records but also wishes to discuss with the mental health provider the treatment he or she provided the client, the purpose of the disclosure would be "to discuss mental health treatment provided to Robert Roe by the mental health program." If the program merely seeks information, the kind of information disclosed would, as in the example above, be limited to a statement that "Robert Roe is being assessed by the XYZ Program"; however, if the program needs to disclose information it has gained in its assessment of Robert Roe to the mental health provider in order to further the discussion or coordinate care, the kind of information disclosed would be "assessment information about Robert Roe."

A program that routinely seeks collateral information from many sources could consider asking the client to sign a consent form that permits it to make a disclosure for purposes of seeking information from collateral sources to any one of a number of entities or persons listed on the consent form. Such a form must still include "the name or title of the individual or the name of the organization" for each collateral source the program may contact.

Even when information is disclosed over the telephone, program staff are required to notify the recipient of the information of the prohibition on redisclosure. Mention should be made of this restriction during the conversation; for example, the staff member could say, "I'll be sending you a written statement that the information I gave you about Mr. Roe may not be redisclosed."

Communications with employers may warrant special consideration. When a client enters treatment voluntarily, program staff should maintain an open mind about whether communications with an employer would be beneficial to the client. A client who tells program staff that his or her employer will not be sympathetic about the decision to enter treatment may well have an accurate picture of the employer's attitude. Should staff insist on communicating with the employer, the client may lose his or her job. If such communication takes place without the client's consent, the program may be faced with a lawsuit.[5]

Communications With Insurance Carriers

Programs must obtain a client's written consent on the form required by the Federal regulations in order to communicate with any third party payer who may be responsible for funding the client's treatment. Some clients do not want their treatment reported to the insurer. Clients whose employers are self-insured may fear they will be fired, demoted, or disciplined, should their employer learn they have a substance abuse problem. Clients whose treatment is covered by health insurance may fear they will lose their benefits and be unable to obtain other coverage once their current insurer discovers they have been treated for a substance abuse problem. What should programs do in these circumstances?

The program clearly cannot make a disclosure to a third party payer without the client's consent. If the third party payer is the client's employer, the program would not only be violating the Federal regulations but also would be risking a lawsuit, should the client be fired or disciplined. If the third party payer is an insurance company, the program is taking similar risks: If the client's insurance is canceled or he or she cannot obtain coverage elsewhere, the program may face a lawsuit.[6]

If a client does not want the insurance carrier to be notified and is unable to pay for treatment, the program may refer the client to a publicly funded program, if one is available.[7] Programs should consult State law to learn whether they may refuse to admit a client who is unable to pay and who will not consent to the necessary disclosures to his or her insurance carrier.

Insurance carriers, particularly managed care entities, are demanding more and more information about the clients covered by their policies and the treatment provided to those clients. Programs need to be sensitive about the amount and kind of information they disclose, because the insurer may use this information to deny benefits to the client. For example, if, in response to a request from the insurer, the program releases the client's entire chart, the insurer may learn from the intake notes that the client's substance abuse problem included both alcohol and illegal drugs. The insurer may then deny benefits, arguing that since its policy does not cover treatment for abuse of drugs other than alcohol, it will not reimburse for treatment when abuse of both alcohol and drugs is involved. As a second example, the insurer may learn that the client began drinking at age 11 and deny benefits for a "preexisting condition." Treatment notes may contain personal information about the client's family life that is extraneous for insurance company review, the sole purpose of which is to determine whether treatment should be covered and, if so, what kind.

Communication Among Agencies

Communication with other care providers

Treatment programs sometimes need to maintain ongoing communication with the referral source or with other professionals providing services to clients. The best way to proceed is to get the client's consent.

In wording the consent form, one should take care to permit the kinds of communications necessary. For example, if the program will need ongoing communication with a mental health provider, the "purpose of the disclosure" would be "coordination of care for Mildred Moe"; "how much and what kind of information to be disclosed" might be "treatment status, treatment issues, progress in treatment." If the program is treating a client who is on probation at work and whose continued employment is contingent on treatment, the "purpose of disclosure" might be "to assist the client to comply with employer's mandates" or "supply periodic reports about treatment"; "how much and what kind of information will be disclosed" might be "progress in treatment." The kinds of information that would be disclosed in the two examples are quite different. The program might well share detailed clinical information about a client with a mental health provider, if it would assist in coordinating care. Disclosure to an employer, by contrast, would generally be limited to a brief statement about the client's progress in treatment. Disclosure of clinical information to an employer generally would be inappropriate.

The program should also be careful in setting the expiration date or event on which expiration of the consent form is based. A consent form with a mental health provider might expire when treatment ends, while a form permitting disclosures to an employer might expire when the client's probationary period at work ends.

Referral for additional services

When a staff member of a treatment program refers a client to another program for services (e.g., domestic violence support or vocational rehabilitation) and makes an appointment for the client, he or she is making a disclosure covered by the Federal regulations—a disclosure that the client has sought or received substance abuse treatment services. A consent form is, therefore, required. If the substance abuse treatment program is part of a larger program to which the client is being referred, a consent form may not be necessary under the Federal rules, since there is an exception for information disclosed to staff within the same program.

Transferring clients to the hospital

Substance abuse treatment programs, particularly those with limited medical resources, may transfer clients to a hospital for intensive medical management and care. How should programs handle such transfers, since they involve a disclosure of client-identifying information?

Programs may deal with this issue in two ways. First, they may ask all clients admitted to treatment to sign a consent form permitting disclosure to the cooperating hospital, should hospitalization be required. Second, they may take advantage of a provision in the Federal regulations that permits a program to make disclosures in a "medical emergency" to medical personnel "who have a need for information about a client for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define "medical emergency" as "a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention" (§2.51). If a client's condition requires emergency treatment, the program may use this exception to communicate with medical personnel at a hospital. Whenever a disclosure is made to cope with a medical emergency, the program must document in the client's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Mandatory reporting to public health authorities

All States require that new cases of acquired immunodeficiency syndrome (AIDS) be reported to public health authorities, which submit this information to the Federal Centers for Disease Control and Prevention. In some cases, they also use it for other purposes. Some States also require the reporting of new cases of human immunodeficiency virus (HIV) infection. States also require reporting of certain infectious diseases, such as tuberculosis and sexually transmitted diseases. The public health authority often uses reports of infectious diseases to engage in "contact tracing," that is, finding others to whom an infected person may have spread the disease.

The types of information that must be reported and for which diseases, who must report, and the purposes to which the information is put vary from State to State. Therefore, program directors must examine their State laws to discover (1) whether they or any member of their staff is a mandated reporter, (2) when reporting is required, (3) what information must be reported and whether it includes client-identifying information, and

(4) what will be done with the information reported.[*]

If State law permits the use of a code rather than a client's name, the program may make the report without the client's consent since no client-identifying information is being revealed.

If client-identifying information must be reported, there are a number of ways programs can comply with State mandatory reporting laws without violating the Federal confidentiality regulations. They include the following:

- **Obtaining consent.** The easiest way to comply with a State law that mandates reporting of client-identifying information to a public health authority is to obtain the client's consent. The information reported by the program may not be redisclosed by the public health authority unless the consent form is drafted to permit redisclosure.
- **Reporting without making a client-identifying disclosure.** If the program is part of another health care facility (for example, a general hospital or mental health program), it can include the client's name in reports if it does so under the name of the parent agency, as long as no information is released that would link the client with substance abuse treatment.
- **Using a Qualified Service Organization Agreement (QSOA).** A treatment program that is required to report clients' names to a public health department also may enter into a QSOA with a general medical care facility or a laboratory that conducts testing or other services for the program. The QSOA, which is explained in detail later in this appendix, permits the program to report the names of clients to the medical care facility or laboratory, which may then report the information, including client names, to the public heath department. However, no information is provided that would link those names with substance abuse treatment.
- **Reporting under the audit and evaluation exception.** One of the exceptions to the general rule prohibiting disclosure without client consent is found in §2.53, which permits programs, under certain conditions, to disclose information to auditors and evaluators. The U.S. Department of Health and Human Services (DHHS) has written two opinion letters that approve the use of the audit and evaluation exception to report HIV-related information to public health authorities.[*] Read together, these two letters suggest that substance abuse programs may report client-identifying information even if that information will be used by the public health department to conduct contact tracing, as long as the health department does not disclose the name of the client to the "contacts" it approaches. The letters also suggest that the public health authorities could use the information to contact the infected client directly. Section 2.53 is intended to permit an outside entity, such as a peer review organization or an accounting firm, to examine or copy a program's records in order to determine whether it is operating in accordance with regulations. It was not intended to permit an outside entity to gain information to perform other tasks or accomplish other social ends. The legal validity of these two letters may, therefore, be considered debatable.

Telephone Calls to Clients

If someone telephones a client at a program, the staff may not reveal that the client is at the program unless the program has a written consent form signed by the client to make a disclosure to that particular caller. Given this restriction, how should a program handle telephone calls to clients? There are at least four options:

- The program can obtain the client's written consent to accept telephone calls from particular people and consult a list of these individuals' names when the client receives a phone call.
- If the client has not consented to receive calls from a particular person, the staff member can put the caller on hold and ask the client if he or she wants to speak to the caller. If the client wants to accept the call, the client, not the staff member, is making the disclosure that he or she is at the treatment program. If the client does not want to speak to the caller, the staff member must tell the caller, "I'm sorry, but I can't tell you whether Tommy Toe is here." At no time may the program reveal, even indirectly, that the person being inquired after is a client at the program.
- The program can uniformly take messages for clients, telling all callers, "I'm sorry, but I cannot tell you if Tommy is here, but if he is I will give him this message." Again, this leaves it up to the client whether to make a disclosure about being in treatment.
- The program can set up a "client phone" that is answered only by clients. Since only clients would answer the telephone and give the phone number to others if the number were unlisted, the program would be making no disclosures. The program should caution clients to act discreetly and thoughtfully when handling calls for others.

Clients Mandated Into Treatment By the Criminal Justice System

Programs treating clients who are required to enter and participate in treatment as part of a criminal justice sanction must follow the Federal confidentiality rules. In addition, some special rules apply when a client is in treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding, and information is being disclosed to the mandating agency.

A consent form or court order is still required before any disclosure may be made about an offender who is mandated into assessment or treatment. However, the rules concerning the length of time that a consent remains valid are different, and a "criminal justice system consent" may not be revoked before its expiration event or date.

The regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

- The anticipated duration of treatment
- The type of criminal proceeding in which the offender is involved
- The need for treatment information in dealing with the proceeding
- When the final disposition will occur
- Anything else the client, program, or criminal justice agency believes is relevant.

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed, namely, "when there is a substantial change in the client's criminal justice system status." A substantial change in status occurs whenever the client moves from one phase of the criminal justice system to the next. For example, if a client is on probation or parole, a change in criminal justice status would occur when the probation or parole ended, either by successful completion or revocation. Thus, the program could provide treatment or periodic reports to the probation or parole officer monitoring the client and could even testify at a revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing. This formula appears to work well.

Concerning revocability of the consent (that is, the conditions under which the offender can take back his or her consent), the regulations provide that the form may state that consent may not be revoked until a specified date arrives or condition occurs. The regulations permit the criminal justice system consent form to be irrevocable, so that a client who has agreed to enter treatment in lieu of prosecution or punishment cannot later prevent the court, probation department, or other agency from monitoring his or her progress. Although a criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the client may freely revoke consent.

Several other considerations relating to criminal justice system referrals are important. First, any information received by one of the eligible criminal justice agencies from a treatment program may be used by that justice agency only in connection with its official duties with respect to that particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals (§2.34(d)). Second, whenever possible, the judge or referring agency should require that a proper criminal justice system consent form be signed by the client at the time he or she is referred to the treatment program. If this is not possible, the treatment program should have the client sign a criminal justice system consent form at his or her first appointment. With a properly signed criminal justice consent form, the treatment program can communicate with the referring criminal justice agency, even if the client appears for assessment or treatment only once. This avoids the problems that may arise if a client mandated into treatment does not sign a proper consent form and leaves before the assessment or treatment has been completed.

If a program fails to have the client sign a criminal justice system form and the client fails to complete the assessment or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the client and ask him or her to sign a consent form. The client is, however, unlikely to do so. It is uncertain whether a court can issue an order to authorize the program to release information about a referred client who has left the program in this type of case, because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a client for a crime only when the crime was "extremely serious." A parole or probation violation generally will not meet that criterion.

Therefore, unless the judge, criminal justice agency, or program obtains consent at the beginning of the assessment or treatment process, the program may be prevented from providing any information to the referring criminal justice agency.

If a client referred by a criminal justice agency never applies for or receives services from the program, that fact may be communicated to the referring agency without client consent (§2.13(c)(2)). As soon as a client has made an appointment to visit the program, a signed consent form or a court order is needed for any disclosures.

Driving While Impaired

Suppose that an intoxicated client arrives at a treatment program but decides not to enter treatment. If the client is not in condition to drive home, what should the program do? First, it can offer the client a ride home or taxi fare for a ride home. Second, it can maintain a room where such a person can "sleep it off." (The program would be wise to obtain the person's consent to alert his or her family.) This strategy can also be used by programs that do not admit clients who are inebriated.

What if the client refuses both offers and leaves the premises, intending to drive home?

Does the program have a duty to call the police to prevent an accident? Does it risk a lawsuit if it fails to do so? This is a question of State law.

In most States, it is unlikely that the program would be liable, particularly if it had made an effort to stop the client from driving. As noted in Chapter 5, in States that follow the *Tarasoff* doctrine, liability has generally been limited to those situations where a client threatens to harm a specific person. Liability has generally not been imposed in situations where a client poses a threat to the community in general.

Liability concerns aside, the program may nonetheless believe it is obligated to call the police if its attempts to prevent the client from driving fail. In doing so, it must take care not to violate the client's confidentiality. For example, the program can call the police and tell them that the driver of a 1991 tan Nissan with a license number "XYZ 123," who is heading downtown from the intersection of Maple and Third streets, is not in a condition to operate a vehicle. The program should ask the police to respond immediately. The program may not tell the police that the client has a substance abuse problem. This means it may not tell the police that the client is impaired by alcohol or drugs and cannot reveal the program's name, since to do so would tell the police that the client has a substance abuse problem.

In order to get the client's license number and a description of his or her car, it may be necessary to detain the client. If it does so, the program should avoid using force, since the client could sue the program for battery or false imprisonment.

Conducting Research

Research about and evaluation of the efficacy of different methods of treatment are essential to advances in the field. But can programs share client-identifying information with researchers and program evaluators? The confidentiality regulations do permit programs to disclose client-identifying information to researchers, auditors, and evaluators without client consent, provided certain safeguards are met (§§2.52, 2.53).

Research

Treatment programs may disclose client-identifying information to persons conducting "scientific research" if the program director determines that the researcher (1) is qualified to conduct the research, (2) has a protocol under which client-identifying information will be kept in accordance with the regulations' security provisions (see §2.16, as described below), and (3) has provided a written statement from a group of three or more independent individuals who have reviewed the protocol and determined that it protects clients' rights. Researchers are prohibited from identifying an individual client in any report or from otherwise disclosing any client identities, except back to the program.[10]

Audit and evaluation

Federal, State, and local government agencies that fund or are authorized to regulate a program, private entities that fund or provide third party payments to a program, and peer review entities performing a utilization or quality control review may review client records on the program premises in order to conduct an audit or evaluation.[11] Any person or entity that reviews client records to perform an audit or conduct an evaluation must agree in writing that it will use the information only to carry out the audit or evaluation and that it will redisclose client information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (§2.66), or (3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(a), (c), (d)). Any other person or entity that is determined by the program director to be qualified to conduct an audit or evaluation and that agrees in writing to abide by the restrictions on redisclosure also may review client records.

Followup research

Research that follows clients for any period of time after they leave treatment presents a special challenge under the Federal regulations. The treatment program, researcher, or evaluator who seeks to contact former clients to gain information about how they are faring after leaving treatment must do so without disclosing to others any information about their connection to the treatment program. If followup contact is attempted by telephone, the caller must make sure he or she is talking to the client before identifying himself or herself or mentioning a connection to the treatment program. For example, asking for "William Woe," when his wife or child has answered the phone, and announcing that one is calling from the "ABC Treatment Program" (or the "Drug Research Corporation") violates the regulations. The program or research agency may form another entity, without a hint of drug or alcohol treatment in its name (for example, Health Research, Inc.) that can contact former clients without worrying about disclosing information simply by giving its name. When a representative of such an entity calls former clients, however, care must be taken that the client is actually on the line before revealing any connection with the treatment program.

If followup is done by mail, the return address should not disclose any information that could lead someone seeing the envelope to conclude that the addressee had been in treatment.

Five Other Exceptions To the General Confidentiality Rule

Reference has been made to other exceptions the Federal confidentiality rules make to the general rule prohibiting disclosure. Presented below are five additional categories of exceptions to the general rule.

Communications That Do Not Disclose Client-Identifying Information

The Federal regulations permit programs to disclose information about a client if the program reveals no client-identifying information. Thus, a program may disclose information about a client if that information does not identify the client as a substance abuser or does not verify anyone else's identification of the client as a substance abuser.

A program may make a disclosure that does not identify a client in two ways. First, it may report aggregate data that give an overview of the clients served in the program or some portion of its population. For example, a program could tell the newspaper that in the last 6 months it had 43 clients, 10 female and 33 male. Second, a program may communicate information about a client in a way that does not reveal the client's status as a drug or alcohol abuse client (§2.12(a)(i)). For example, a program that provides services to clients with other problems or illnesses as well as alcohol or drug addiction may disclose information about a particular client as long as the fact that the client has a substance abuse problem is not revealed. To cite a more specific example, a counselor from a program that is part of a general hospital could call the police about a threat a client made, as long as he or she does not disclose that the client has an alcohol or drug abuse problem or is a client of the treatment program.

Programs that provide only alcohol or drug services or that provide a full range of services but are identified by the general public as drug or alcohol programs cannot disclose information that identifies a client under this exception, since letting someone know a counselor is calling from the "XYZ Program" will automatically identify the client as someone who got services from the program. However, a freestanding program may sometimes make "anonymous" disclosures, that is, disclosures that do not mention the name of the program or otherwise reveal the client's status as an alcohol or drug abuser.

Court-Ordered Disclosures

A State or Federal court may issue an authorizing order that will permit a program to make a disclosure about a client that would otherwise be forbidden. A court may issue one of these orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant, even when signed by a judge, is not sufficient standing alone to require, or even to permit, a program to disclose information (§2.61).[12]

Before a court can issue an authorizing order, the program and any client whose records are sought must be given notice of the application for the order and some opportunity to make an oral or a written statement to the court.[13] Generally, the application and any court order must use fictitious names for any known client. All court proceedings in connection with the application must remain confidential, unless the client requests otherwise (§§2.64(a), (b), 2.65, 2.66).

Before issuing an authorizing order, the court must find that there is "good cause" for the disclosure. A court may find "good cause" only if it determines that the public interest and the need for disclosure outweigh any adverse effect that the disclosure will have on the client, the doctor-client or counselor-client relationship, and the effectiveness of the program's treatment services. Before it may issue an order, the court also must find that other ways of obtaining the information are unavailable or would be ineffective (§2.64(d)).[14] The judge may examine the records before making a decision (§2.64(c)).

There are also limits on the scope of disclosure that a court may authorize, even when it finds good cause. The disclosure must be limited to information essential to fulfill the purpose of the order and restricted to those persons who need the information for that purpose. The court also should take any other steps that are necessary to protect the client's confidentiality, including sealing court records from public scrutiny (§2.64(e)).

The court may order disclosure of "confidential communications" by a client to the program only if the disclosure is necessary to protect against a threat to life or of serious bodily injury or to investigate or prosecute an extremely serious crime (including child abuse), or is in connection with a proceeding at which the client has already presented evidence concerning confidential communications (§2.63).

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a client for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define *medical emergency* as a situation that poses an immediate threat to health and requires immediate medical intervention (§2.51).

The medical emergency exception permits disclosure only to medical personnel. It cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including parents. Under this exception, however, a program could notify a private physician about a suicidal client so that medical intervention could be arranged. The physician, in turn, could notify a client's parents or other relatives, as long as no mention were made of the client's substance abuse problem. Whenever a disclosure is made to cope with a medical emergency, the program must document in the client's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Qualified Service Organization Agreements

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into a QSOA. A *QSOA* (Figure B-4) is a written agreement between a program and a person providing services to the program in which that person (1) acknowledges that in receiving, storing, processing, or otherwise dealing with any client records from the program, he or she is fully bound by [the Federal confidentiality] regulations; and (2) promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to client records except as permitted by these regulations (§§2.11, 2.12(c)(4)).

A QSOA should be used only when an agency or official outside of the program, for example, a clinical laboratory or data-processing agency, is providing a service to the program itself. An example is when laboratory analysis or data processing is performed for the program by an outside agency. A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. QSOAs may not be used between programs providing alcohol and drug services.

Internal Program Communications

The Federal regulations permit some information to be disclosed to individuals within the same program:

> The restrictions on disclosure in these regulations do not apply to communications of information between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of alcohol or drug abuse if the communications are (i) within a program or (ii) between a program and an entity that has direct administrative control over that program. (§2.12(c)(3))

In other words, staff (including full- or part-time employees and unpaid volunteers) who have access to client records because they work for or administratively direct the program may consult among themselves or otherwise share information if their substance abuse work so requires

Does this exception allow a treatment program that is part of a larger entity, such as a hospital, to share confidential information with others that are not part of the treatment unit? The answer to this question is quite complicated. In brief, there are circumstances under which the treatment unit may share information with other units that are part of the greater entity to which it belongs. Before such an internal communication system is set up within a large institution, however, it is essential that an expert in the area be consulted.

Figure B-4

Qualified Service Organization Agreement

XYZ Service Center ("the Center") and the ______________________________

____

(Name of the program)

("the Program") hereby enter into a qualified service organization agreement, whereby the Center agrees to provide the following services:

____

____

____

(Nature of services to be provided)

Furthermore, the Center:

1. Acknowledges that in receiving, storing, processing, or otherwise dealing with any information from the Program about the clients in the Program, it is fully bound by the provisions of the Federal Regulations governing Confidentiality of Alcohol and Drug Abuse Client Records, 42 C.F.R. Part 2; and

2. Undertakes to resist in judicial proceedings any effort to obtain access to information pertaining to clients otherwise than as expressly provided for in the Federal confidentiality regulations, 42 C.F.R. Part 2.

Executed this _____ day of __________, 199__.

______________________	______________________
President XYZ Service Center (Address)	Program Director (Name of Program) (Address)

Other Requirements

Client Notice and Access to Records

The Federal confidentiality regulations require programs to notify clients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to clients when they enter the program or shortly thereafter (§2.22(a)). The regulations contain a sample notice that may be used for this purpose.

Unless State law grants the right of client access to records, programs have the right to decide when to permit clients to view or obtain copies of their records. The Federal regulations do not require programs to obtain written consent from clients before permitting them to see their own records.

Security of Records

The Federal regulations require programs to keep written records in a secure room, locked file cabinet, safe, or other similar container. The program should establish written procedures that regulate access to and use of client records. The program director or a single staff person should be designated to process inquiries and requests for information (§2.16).

Conclusion

Administrators and staff members of substance abuse treatment programs should become thoroughly familiar with the many legal issues affecting their work. Such knowledge can prevent costly mistakes. Because legal requirements often vary by State and change over time, it is also essential that programs find a reliable source to whom they may turn for up-to-date information, advice, and training.

Endnotes

2. Citations throughout this appendix in the form "§2..." refer to specific sections of 42 C.F.R., Part 2, Implementing the Substance Abuse and Mental Health Services Administration (42 U.S.C. §290dd-2).

3. Only clients who have "applied for or received" services from a program are protected. If a client has not personally sought help from the program or has not yet been evaluated or counseled by a program, the program is free to discuss the client's drug or alcohol problems with others. The Federal regulations govern from the moment the client applies for services or the program first conducts an evaluation or begins counseling.

4. Subpoenas and search and arrest warrants are discussed in Chapter 5.

5. Although Federal and, in some cases, State laws may prohibit the employer from firing employees or taking other action simply because they have entered treatment, discriminatory practices against recovering people continue.

6. Some States prohibit insurance companies from discriminating against individuals who have received substance abuse treatment; however, discriminatory practices continue. Insurance companies routinely share information about policy holders. Although the Federal regulations prohibit insurance companies from sharing information from a treatment program with other carriers, that prohibition is no guarantee that such redisclosure will not take place.

7. If a client who has signed a consent form permitting the program to make disclosures to a third party payer later revokes his or her consent, the program can bill the third party payer for services provided before consent was revoked. A program cannot, however, make any disclosures to the third party payer in order

to receive reimbursement for services rendered after the client revoked consent (§2.31(a)(8)).

8. If the State's reporting law is intended only to gather information for research purposes, treatment programs can include clients' names in their reports, if the public health department complies with §2.52 of the Federal regulations. That section permits release of client-identifying information to researchers when (1) they are qualified to conduct the research; (2) they have a research protocol to protect client-identifying information, and a group of three or more individuals independent of the research project have reviewed the protocol and found it adequate; and (3) they agree not to redisclose clients' names or identifying information except back to the program and not to identify any client in a report. In most cases, a department of public health will easily satisfy the first requirement. The U.S. Department of Health and Human Services (DHSS) has suggested in opinion letters that the second requirement may not apply when the research is intended to track the incidence and causation of diseases. Thus, if the State is gathering information only for research purposes, the program can probably make reports including clients' names, if the department agrees not to redisclose clients' names or identifying information except back to the program and not to identify any client in a report.

9. See Letter to Oklahoma State Department of Health from the Legal Adviser to the U.S. Alcohol, Drug Abuse, and Mental Health Administration, dated September 2, 1988, and Letter to the New York State Department of Health from the Acting General Counsel to the U.S. DHHS, dated May 17, 1989.

10. Two statutes (42 U.S.C. §241[d] and 21 U.S.C. §872[c]), both of which cover research into drug use, permit the Secretary of DHHS and the U.S. Attorney General, respectively, to authorize researchers to withhold the names and identities of research subjects. The statutes both state that the researcher "may not be compelled in any Federal, State, or local civil, criminal, administrative, legislative, or other proceeding" to identify the subjects of research for which such authorization was obtained. Such authorization is commonly called a "certificate of confidentiality." Whether or not research investigators have obtained an authorization from the Attorney General or the Secretary of DHHS, however, they must comply with the prohibitions on redisclosure discussed in this section of the chapter if they have been given access to clients' records in a federally assisted treatment program.

11. These particular entities also may copy or remove records, but only if they agree in writing to maintain client-identifying information in accordance with the regulations' security requirements (see §2.16), to destroy all client-identifying information when the audit or evaluation is completed, and to redisclose client information only (1) back to the program, (2) in accordance with a court order to investigate or prosecute the program (§2.66), or (3) to a government agency overseeing a Medicare or Medicaid audit or evaluation (§2.53(b)).

12. For information on how to deal with subpoenas, see Chapter 5 and *Confidentiality: A Guide to the Federal Law and Regulations*, New York: Legal Action Center, 1995.

13. If the information is being sought to investigate or prosecute a client, only the program need be notified (§2.65). If the information is sought to investigate or prosecute the program, no prior notice is required (§2.66).

14. If the purpose of seeking the court order is to obtain authorization to disclose information in order to investigate or prosecute a client for a crime, the court also must find that (1) the crime involved was extremely serious, such as an act causing or threatening to cause death or serious injury; (2) the records sought are likely to

contain information of significance to the investigation or prosecution; (3) there is no other practical way to obtain the information; and (4) the public interest in disclosure outweighs any actual or potential harm to the client, the doctor-client relationship, and the ability of the program to provide services to other clients.

When law enforcement personnel seek the order, the court also must find that the program had an opportunity to be represented by independent counsel. If the program is a government entity, it must be represented by independent counsel, §2.65(d).

Appendix C
Instruments

This appendix reproduces the following tools:

- Abuse Assessment Screen (in English and Spanish)
- Danger Assessment
- Psychological Maltreatment of Women Inventory (PMWI)
- Revised Conflict Tactics Scale (CTS2)

Although these instruments have been used extensively in research settings, they have not been validated as clinical tools; nor do they have instructions for scoring. The PMWI and the CTS2, in particular, were designed as research tools, not clinical tools, and do not have cutting scores (the score beyond which a person has a problem). All the instruments in this appendix can, however, serve to open dialogue with a client, elicit information, promote discussion, and help evaluate a program.

Abuse Assessment Screen (*English Version)*

1. **WITHIN THE LAST YEAR,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? **YES** **NO**

   If YES, by whom?______________________________

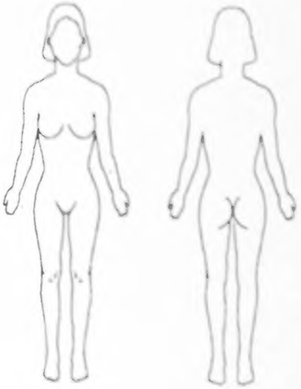
   Total number of times ______________________________

2. **SINCE YOU'VE BEEN PREGNANT,** have you been hit, slapped, kicked, or otherwise physically hurt by someone? **YES** **NO**

   If YES, by whom? ______________________________

   Total number of times ______________________________

MARK THE AREA OF INJURY ON THE BODY MAP, SCORE EACH INCIDENT ACCORDING TO THE FOLLOWING SCALE: **SCORE**



1 = Threats of abuse including use of a weapon ______

2 = Slapping, pushing; no injuries and/or lasting pain ______

3 = Punching, kicking, bruises, cuts and/or continuing pain ______

4 = Beating up, severe contusions, burns, broken bones ______

5 = Head injury, internal injury, permanent injury ______

6 = Use of weapon; wound from weapon ______

If any of the descriptions for the higher number apply, use the higher number.

3. **WITHIN THE LAST YEAR,** has anyone forced you to have sexual activities? **YES** **NO**

   If YES, by whom? ______________________________

Encuesta Sobre El Maltrato (*Spanish Version*)

1. **DURANTE EL ÚLTIMO AÑO**, fué golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien? SI NO

   Si la respuesta es "SI" por quien(es)?________________

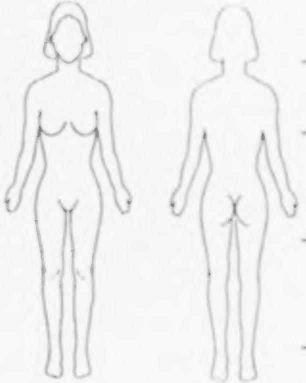
   Cuantas veces?________________________________

2. **DESDE QUE SALIO EMBARAZADA**, ha sido golpeada, bofeteada, pateada, o lastimada fisicamente de alguna otra manera por alguien?________________________ SI NO

   Si la respuesta es "SI" por quien(es)? ________________

   Cuantas veces?________________________________

EN EL DIAGRAMA ANATÓMICO, MARQUE LAS PARTES DE SU CUERPO QUE HAN SIDO LASTIMADAS. VALORE CADA INCIDENTE USANDO LAS SIGUIENTE ESCALA: GRADO



1 = Amenazas de maltrato que incluyen el uso de un arma _____

2 = Bofeteadas, permanentel ompujones sin lesiones fisicas o dolor permanente _____

3 = Moquestos, patadas, moretones, heridas y/o dolor continuo _____

4 = Molida a palos, contusiones severas, quemaduras, fracturas de huesos _____

5 = Heridas en la cabeza, lesiones internas, lesiones permanentes _____

6 = Uso de armas, herida por arma _____

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Si cualquiera de las situaciones valora un numero alto en la escala, úselo.

3. **DURANTE EL ÚLTIMO AÑO**, fué forzada a tener relaciones sexuales? **SI** **NO**

Si la respuesta es "SI" por quien(es)____________________

Cuantas veces?____________________

Developed by the Nursing Research Consortium on Violence and Abuse.

Reproduced with permission from J. McFarlane & B. Parker (1994). *Abuse During Pregnancy: A Protocol for Prevention and Intervention*. White Plains, NY: The March of Dimes Birth Defects Foundation, pp. 22–23.

Danger Assessment

Several risk factors have been associated with homicides (murders) of both batterers and battered women in research conducted after the murders have taken place. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of severe battering and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were beaten by your husband or partner. Write on that date how bad the incident was according to the following scale (if any of the descriptions for the higher number apply, use the higher number):

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

Mark **YES** or **NO** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

________ 1. Has the physical violence increased in frequency over the past year?

________ 2. Has the physical violence increased in severity over the past year and/or has a weapon or threat from a weapon ever been used?

________ 3. Does he ever try to choke you?

________ 4. Is there a gun in the house?

________ 5. Has he ever forced you to have sex when you did not wish to do so?

________ 6. Does he use drugs? By drugs, I mean "uppers" or amphetamines, speed, angel dust, cocaine, "crack," street drugs, or mixtures.

________ 7. Does he threaten to kill you and/or do you believe he is capable of killing you?

________ 8. Is he drunk every day or almost every day? (In terms of quantity of alcohol.)

________ 9. Does he control most or all of your daily activities? For instance: Does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here: ____________.)

________ 10. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: __________.)

________ 11. Is he violently and constantly jealous of you? (For instance, does he say, "If I can't have you, no one can.")

________ 12. Have you ever threatened or tried to commit suicide?

________ 13. Has he ever threatened or tried to commit suicide?

________ 14. Is he violent toward your children?

________ 15. Is he violent outside of the home?

____

________ Total "Yes" Answers

Thank you. Please talk to your nurse, advocate, or counselor about what the Danger Assessment means in terms of your situation.

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Please share with the author the results of any research (raw or coded data) that is done with the instrument and/or an approximate number of women with whom the instrument was used, a description of their demographics, their mean score, and the setting in which data were collected. Please send this information within the next year. Also please send comments (positive and negative) and suggestions for improvement from battered women themselves, advocates, and professionals who are involved in its use.

Sources:

Campbell, J. Nursing assessment for risk of homicide in battered women. *Advances in Nursing Science* 8:36–51, 1986.

Campbell, J.C. Prediction of homicide of and by battered women. In: Campbell, J.C., ed. *Assessing Dangerousness. Violence by Sexual Offenders, Batterers, and Child Abusers.* Thousand Oaks, CA: Sage Publications, Inc., 1995.

The Psychological Maltreatment Of Women Inventory (PMWI)

The PMWI is a 58-item test designed to measure the extent and nature of abuse toward women in a relationship. The questionnaire below is given to women survivors of abuse. The version for male perpetrators includes identical behaviors but reverses the pronouns and direction of abuse.

Women's Scale Items

How often, if at all, did the behavior described in each item occur in the past six months (never, rarely, sometimes, frequently, or very frequently)?

1. My partner put down my physical appearance.
2. My partner insulted me or shamed me in front of others.
3. My partner treated me like I was stupid.
4. My partner was insensitive to my feelings.
5. My partner told me I couldn't manage or take care of myself without him.
6. My partner put down my care of the children.
7. My partner criticized the way I took care of the house.
8. My partner said something to spite me.
9. My partner brought up something from the past to hurt me.
10. My partner called me names.
11. My partner swore at me.
12. My partner yelled and screamed at me.
13. My partner treated me like an inferior.
14. My partner sulked or refused to talk about a problem.
15. My partner stomped out of the house or yard during a disagreement.
16. My partner gave me the silent treatment, or acted as if I wasn't there.
17. My partner withheld affection from me.
18. My partner did not let me talk about my feelings.
19. My partner was insensitive to my sexual needs and desires.
20. My partner demanded obedience to his whims.
21. My partner became upset if dinner, housework, or laundry was not done when he thought it should be.
22. My partner acted like I was his personal servant.
23. My partner did not do a fair share of household tasks.
24. My partner did not do a fair share of child care.
25. My partner ordered me around.
26. My partner monitored my time and made me account for where I was.
27. My partner was stingy in giving me money to run our home.
28. My partner acted irresponsibly with our financial resources.
29. My partner did not contribute enough to supporting our family.
30. My partner used our money or made important financial decisions without talking to me about it.

31. My partner kept me from getting medical care that I needed.
32. My partner was jealous or suspicious of my friends.
33. My partner was jealous of other men.
34. My partner did not want me to go to school or other self-improvement activities.
35. My partner did not want me to socialize with my female friends.
36. My partner accused me of having an affair with another man.
37. My partner demanded that I stay home and take care of the children.
38. My partner tried to keep me from seeing or talking to my family.
39. My partner interfered in my relationships with other family members.
40. My partner tried to keep me from doing things to help myself.
41. My partner restricted my use of the car.
42. My partner restricted my use of the telephone.
43. My partner did not allow me to go out of the house when I wanted to go.
44. My partner refused to let me work outside of the home.
45. My partner told me my feelings were irrational or crazy.
46. My partner blamed me for his problems.
47. My partner tried to turn our family, friends, and children against me.
48. My partner blamed me for causing his violent behavior.
49. My partner tried to make me feel like I was crazy.
50. My partner's moods changed radically, from calm to angry, or vice versa.
51. My partner blamed me when he was upset about something, even when it had nothing to do with me.
52. My partner tried to convince my friends, family, or children that I was crazy.
53. My partner threatened to hurt himself if I left him.
54. My partner threatened to hurt himself if I didn't do what he wanted me to do.
55. My partner threatened to have an affair with someone else.
56. My partner threatened to leave the relationship.
57. My partner threatened to take the children away from me.
58. My partner threatened to have me committed to a mental institution.

Source: Tolman, R.M. The development of a measure of psychological maltreatment of women by their male partners. *Violence and Victims* 4(3):159–177, 1989.

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The Revised Conflict Tactics Scale (CTS2) (for Couples)

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The Revised Conflict Tactics Scale (CTS2) is copyrighted by the test authors and may be reproduced only with their express permission. Permission will be granted on the basis of completing a one-page permission form and signing a user agreement. The agreement commits the user to either (1) carry out and publish, or make available to the test authors, psychometric analyses, including frequency distribution, mean, standard deviation, and alpha coefficient of reliability for each scale; or (2) provide the test authors with the raw data for each subject tested in a form that will enable the test authors to compute these statistics, together with as much demographic information as possible for each subject. The test authors agree to only use this information for psychometric analyses and to acknowledge the source of the data. The user providing the information retains the sole right to use the data for substantive purposes. Copies of the permission form and user agreement are available from Murray A. Straus, Family Research Laboratory, University of New Hampshire, Durham, NH 03824; e-mail: mas2@christic.unh.edu; telephone: (603) 862-2594; fax: (603) 862-1122.

Relationship Behaviors

No matter how well a couple gets along, there are times when they disagree, get annoyed with the other person, want different things from each other, or just have spats or fights because they are in a bad mood, are tired, or for some other reason. Couples also have many different ways of trying to settle their differences. This is a list of things that might happen when you have differences. Please circle how many times you did each of these things in the past year, and how many times your partner did them in the past year. If you or your partner did not do one of these things in the past year, but it happened before that, circle "7."

How often did this happen?

1 = Once in the past year
2 = Twice in the past year
3 = 3–5 times in the past year
4 = 6–10 times in the past year
5 = 11–20 times in the past year
6 = More than 20 times in the past year
7 = Not in the past year, but it did happen before
0 = This has never happened

1. I showed my partner I cared even though we disagreed.	**1 2 3 4 5 6**	**7 0**
2. My partner showed care for me even though we disagreed.	**1 2 3 4 5 6**	**7 0**
3. I explained my side of a disagreement to my partner.	1 2 3 4 5 6	7 0
4. My partner explained his or her side of a disagreement to me.	1 2 3 4 5 6	7 0
5. I insulted or swore at my partner.	**1 2 3 4 5 6**	**7 0**
6. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
7. I threw something at my partner that could hurt.	1 2 3 4 5 6	7 0
8. My partner did this to me.	1 2 3 4 5 6	7 0
9. I twisted my partner's arm or hair.	**1 2 3 4 5 6**	**7 0**
10. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
11. I had a sprain, bruise, or small cut because of a fight with my	1 2 3 4 5 6	7 0

partner.		
12. My partner had a sprain, bruise, or small cut because of a fight with me.	1 2 3 4 5 6	7 0
13. I showed respect for my partner's feelings about an issue.	**1 2 3 4 5 6**	**7 0**
14. My partner showed respect for my feelings about an issue.	**1 2 3 4 5 6**	**7 0**
15. I made my partner have sex without a condom.	1 2 3 4 5 6	7 0
16. My partner did this to me.	1 2 3 4 5 6	7 0
17. I pushed or shoved my partner.	**1 2 3 4 5 6**	**7 0**
18. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
19. I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex.	1 2 3 4 5 6	7 0
20. My partner did this to me.	1 2 3 4 5 6	7 0
21. I used a knife or gun on my partner.	**1 2 3 4 5 6**	**7 0**
22. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
23. I passed out from being hit on the head by my partner in a fight.	1 2 3 4 5 6	7 0
24. My partner passed out from being hit on the head in a fight with me.	1 2 3 4 5 6	7 0
25. I called my partner fat or ugly.	**1 2 3 4 5 6**	**7 0**
26. My partner called me fat or ugly.	**1 2 3 4 5 6**	**7 0**
27. I punched or hit my partner with something that could hurt.	1 2 3 4 5 6	7 0
28. My partner did this to me.	1 2 3 4 5 6	7 0
29. I destroyed something belonging to my partner.	**1 2 3 4 5 6**	**7 0**
30. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
31. I went to a doctor because of a fight with my partner.	1 2 3 4 5 6	7 0
32. My partner went to a doctor because of a fight with me.	1 2 3 4 5 6	7 0
33. I choked my partner.	**1 2 3 4 5 6**	**7 0**
34. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
35. I shouted or yelled at my partner.	1 2 3 4 5 6	7 0
36. My partner did this to me.	1 2 3 4 5 6	7 0
37. I slammed my partner against a wall.	**1 2 3 4 5 6**	**7 0**
38. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
39. I said I was sure we could work out a problem.	1 2 3 4 5 6	7 0
40. My partner was sure we could work it out.	1 2 3 4 5 6	7 0
41. I needed to see a doctor because of a fight with my partner, but I didn't.	**1 2 3 4 5 6**	**7 0**
42. My partner needed to see a doctor because of a fight with me, but didn't.	**1 2 3 4 5 6**	**7 0**
43. I beat up my partner.	1 2 3 4 5 6	7 0
44. My partner did this to me.	1 2 3 4 5 6	7 0
45. I grabbed my partner.	**1 2 3 4 5 6**	**7 0**
46. My partner did this to me.	**1 2 3 4 5 6**	**7 0**
47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex.	1 2 3 4 5 6	7 0
48. My partner did this to me.	1 2 3 4 5 6	7 0

49. I stomped out of the room or house or yard during a disagreement. 1 2 3 4 5 6 7 0

50. My partner did this to me. 1 2 3 4 5 6 7 0

51. I insisted on sex when my partner did not want to (but did not use physical force). 1 2 3 4 5 6 7 0

52. My partner did this to me. 1 2 3 4 5 6 7 0

53. I slapped my partner. 1 2 3 4 5 6 7 0

54. My partner did this to me. 1 2 3 4 5 6 7 0

55. I had a broken bone from a fight with my partner. 1 2 3 4 5 6 7 0

56. My partner had a broken bone from a fight with me. 1 2 3 4 5 6 7 0

57. I used threats to make my partner have oral or anal sex. 1 2 3 4 5 6 7 0

58. My partner did this to me. 1 2 3 4 5 6 7 0

59. I suggested a compromise to a disagreement. 1 2 3 4 5 6 7 0

60. My partner did this to me. 1 2 3 4 5 6 7 0

61. I burned or scalded my partner on purpose. 1 2 3 4 5 6 7 0

62. My partner did this to me. 1 2 3 4 5 6 7 0

63. I insisted my partner have oral or anal sex (but did not use physical force). 1 2 3 4 5 6 7 0

64. My partner did this to me. 1 2 3 4 5 6 7 0

65. I accused my partner of being a lousy lover. 1 2 3 4 5 6 7 0

66. My partner accused me of this. 1 2 3 4 5 6 7 0

67. I did something to spite my partner. 1 2 3 4 5 6 7 0

68. My partner did this to me. 1 2 3 4 5 6 7 0

69. I threatened to hit or throw something at my partner. 1 2 3 4 5 6 7 0

70. My partner did this to me. 1 2 3 4 5 6 7 0

71. I felt physical pain that still hurt the next day because of a fight with my partner. 1 2 3 4 5 6 7 0

72. My partner still felt physical pain the next day because of a fight we had. 1 2 3 4 5 6 7 0

73. I kicked my partner. 1 2 3 4 5 6 7 0

74. My partner did this to me. 1 2 3 4 5 6 7 0

75. I used threats to make my partner have sex. 1 2 3 4 5 6 7 0

76. My partner did this to me. 1 2 3 4 5 6 7 0

77. I agreed to try a solution to a disagreement my partner suggested. 1 2 3 4 5 6 7 0

78. My partner agreed to try a solution I suggested. 1 2 3 4 5 6 7 0

Scoring

The principles for scoring the CTS2 have been previously described in the CTS1 manual (Straus, 1995) and in Straus and Gelles (1990). Therefore, only the most basic aspects of scoring are presented here. The reader is referred to these other sources for further information.

The CTS2 is scored by adding the response number (i.e., the number of times something happened) midpoint for each category chosen by the participant. Categories 0, 1, and 2 do not have midpoints, and responses for these categories are scored 0, 1, and 2, respectively. For Category 3 (3–5 times), the midpoint is 4; for Category 4 (6–10 times), the midpoint is 8; and for Category 5 (11–20 times), it is 15. The assigned scores for responses to Categories 3, 4, and 5 are, respectively, 4, 8 , and 15. For Category 6 responses (20 times in the past year), the authors recommend assigning a score of 25.

Responses for Category 7 ("Not in the past year, but it did happen before") may be used in two ways: (1) When scores for the previous year are desired (the usual use of the CTS2), Category 7 is assigned a score of 0; and (2) to obtain a relationship prevalence measure of physical assault (i.e., Did an assault ever occur?), respondents who answer 1–7 are assigned a score of 1 ("yes").

When the CTS2 is used for research with any type of sample except cases known to be violent (e.g., men in a batterer treatment program), the test authors recommend that two variables be created for the physical assault, sexual coercion, and physical injury scales: a prevalence variable and a chronicity variable. The prevalence variable is a 0-or-1 dichotomy, with a score of 1 assigned if one or more of the acts in the scale occurred. The chronicity variable is the number of times the act(s) in the scale occurred among those who engaged in at least one of the acts in the scale. If the CTS2 is used with a person (or group member) who is known to be violent, separate prevalence and chronicity variables are not required because prevalence is already known.

Source

Straus, M.A.; Hamby, S.L.; Boney-McCoy, S.; and Sugarman, D.B. The Revised Conflict Tactics Scale (CTS2): Development and preliminary psychometric data. *Journal of Family Issues* 17(3):283–316, 1996.

References

Straus, M.A. *Manual for the Conflict Tactics Scales.* Durham, NH: Family Research Laboratory, University of New Hampshire, 1995.

Straus, M.A., and Gelles, R.J. *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families.* New Brunswick, NJ: Transaction Publishing, 1990.

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Appendix D

Sample Personalized Safety Plan For Domestic Violence Survivors

Name: ____________________

Date: ____________________

Review dates: ______________

____

____

Personalized Safety Plan

The following steps represent my plan for increasing my safety and preparing in advance for the possibility for further violence. Although I do not have control over my partner's violence, I do have a choice about how to respond to him/her and how to best get myself and my children to safety.

Step 1: Safety during a violent incident. Women cannot always avoid violent incidents. In order to increase safety, battered women may use a variety of strategies.

I can use some or all of the following strategies:

A. If I decide to leave, I will ____________________. (Practice how to get out safely. What doors, windows, elevators, stairwells, or fire escapes would you use?)

B. I can keep my purse and car keys ready and put them (place) ________________ in order to leave quickly.

C. I can tell ________________ about the violence and request they call the police if they hear suspicious noises coming from my house.

I can also tell ____________________________ about the violence and request they call the police if they hear suspicious noises coming from my house.

D. I can teach my children how to use the telephone to contact the police and the fire department.

E. I will use ____________________ as my code word with my children or my friends so they can call for help.

F. If I have to leave my home, I will go ____________________. (Decide this even if you don't think there will be a next time.)

If I cannot go to the location above, then I can go to ______________________ or ________________.

G. I can also teach some of these strategies to some/all of my children.

H. When I expect we are going to have an argument, I will try to move to a space that is lowest risk, such as ____________________________________. (Try to avoid arguments in the bathroom, garage, kitchens, near weapons or in rooms without access to an outside door.)

I. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

Step 2: Safety when preparing to leave. Battered women frequently leave the residence they share with the battering partner. Leaving must be done with a careful plan in order to increase safety. Batterers often strike back when they believe that a battered woman is leaving a relationship.

I can use some or all of the following safety strategies:

A. I will leave money and an extra set of keys with ____________________ so I can leave quickly.

B. I will keep copies of important documents or keys at ___________________________.

C. I will open a savings account by _____________________ (date), to increase my independence.

D. Other things I can do to increase my independence include:

____

____

____

E. The domestic violence program's hotline number is _________________________.
I can seek shelter by calling this hotline.

F. I can keep change for phone calls on me at all times. I understand that if I use my telephone credit card, the following month the telephone bill will tell my batterer those numbers that I called after I left. To keep my telephone communications confidential, I must either use coins or I might get a friend to permit me to use their telephone credit card for a limited time when I first leave.

G. I will check with ___________________ and ___________________ to see who would be able to let me stay with them or lend me some money.

H. I can leave extra clothes with ____.

I. I will sit down and review my safety plan every ______________________________ in order to plan the safest way to leave the residence. _____________________________ (domestic violence advocate or friend) has agreed to help me review this plan.

J. I will rehearse my escape plan and, as appropriate, practice it with my children.

Step 3: Safety in my own residence. There are many things that a woman can do to increase her safety in her own residence. It may impossible to do everything at once, but safety measures can be added step by step.

Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install security systems including additional locks, window bars, poles to wedge against doors, an electronic system, etc.

D. I can purchase rope ladders to be used for escape from second floor windows.

E. I can install smoke detectors and purchase fire extinguishers for each floor in my house/apartment.

F. I can install an outside lighting system that lights up when a person is coming close to my house.

G. I will teach my children how to use the telephone to make a collect call to me and to (friend/minister/other) in the event that my partner takes the children.

H. I will tell people who take care of my children which people have permission to pick up my children and that my partner is not permitted to do so. The people I will inform about pick-up permission include

____ (school),

____ (day care staff),

____ (babysitter),

____ (Sunday school teacher),

____ (teacher),

____ and (others).

I. I can inform ____________________________________ (neighbor), ________________________ (pastor), and ________________________ (friend) that my partner no longer resides with me and they should call the police if he is observed near my residence.

Step 4: Safety with a protection order. Many batterers obey protection orders, but one can never be sure which violent partner will obey and which will violate protection orders. I recognize that I may need to ask the police and the courts to enforce my protection order.

The following are some steps that I can take to help the enforcement of my protection order:

A. I will keep my protection order ________________________ (location). (Always keep it on or near your person. If you change purses, that's the first thing that should go in.)

B. I will give my protection order to police departments in the community where I work, in those communities where I usually visit family or friends, and in the community where I live.

C. There should be a county registry of protection orders that all police departments can call to confirm a protection order. I can check to make sure that my order is in the registry. The telephone number for the county registry of protection orders is __________________.

D. For further safety, if I often visit other counties in my state, I might file my protection order with the court in those counties. I will register my protection order in the following counties: __________________, ________________________, and ________________________.

E. I can call the local domestic violence program if I am not sure about B, C, or D above or if I have some problem with my protection order.

F. I will inform my employer, my minister, my closest friend and ____________________ and ____________________ that I have a protection order in effect.

G. If my partner destroys my protection order, I can get another copy from the courthouse by going to [the office] located at ____________________________

H. If my partner violates the protection order, I can call the police and report a violation, contact my attorney, call my advocate, and/or advise the court of the violation.

I. If the police do not help, I can contact my advocate or attorney and will file a complaint with the chief of the police department.

J. I can also file a private criminal complaint with the district justice in the jurisdiction where the violation occurred or with the district attorney. I can charge my battering partner with a violation of the protection order and all the crimes that he commits in violating the order. I can call the domestic violence advocate to help me with this.

Step 5: Safety on the job and in public. Each battered woman must decide if and when she will tell others that her partner has battered her and that she may be at continued risk. Friends, family and coworkers can help to protect women. Each woman should consider carefully which people to invite to help secure her safety.

I might do any or all of the following:

A. I can inform my boss, the security supervisor and ______________________________ at work of my situation.

B. I can ask ____ to help screen my telephone calls at work.

C. When leaving work, I can ____.

D. When driving home if problems occur, I can _________________________________.

E. If I use public transit, I can ____.

F. I can use different grocery stores and shopping malls to conduct my business and shop at hours that are different than those when residing with my battering partner.

G. I can use a different bank and take care of my banking at hours different from those I used when residing with my battering partner.

H. I can also ____.

Step 6: Safety and drug or alcohol use. Most people in this culture use alcohol. Many use mood-altering drugs. Much of this use is legal and some is not. The legal outcomes of using illegal drugs can be very hard on a battered woman, may hurt her relationship with her children and put her at a disadvantage in other legal actions with her battering partner. Therefore, women should carefully consider the potential cost of the use of illegal drugs. But beyond this, the use of any alcohol or other drugs can reduce a woman's awareness and ability to act quickly to protect herself from her battering partner. Furthermore, the use of alcohol or other drugs by the batterer may give him/her an excuse to use violence. Therefore, in the context of drug or alcohol use, a woman needs to make specific safety plans.

If drug or alcohol use has occurred in my relationship with the battering partner, I can enhance my safety by some or all of the following:

A. If I am going to use, I can do so in a safe place and with people who understand the risk of violence and are committed to my safety.

B. I can also ____.

C. If my partner is using, I can ______________________________.

D. I might also ______________________________________.

E. To safeguard my children, I might ________________________ and
________________.

Step 7: Safety and my emotional health. The experience of being battered and verbally degraded by partners is usually exhausting and emotionally draining. The process of building a new life for myself takes much courage and incredible energy.

To conserve my emotional energy and resources and to avoid hard emotional times, I can do some of the following:

A. If I feel down and ready to return to a potentially abusive situation, I can
____________________.

B. When I have to communicate with my partner in person or by telephone, I can
____.

C. I can try to use "I can . . ." statements with myself and to be assertive with others.

D. I can tell myself, "______________________________" whenever I feel others are trying to control or abuse me.

E. I can read ________________ to help me feel stronger.

F. I can call ____________________, ____________________ and
____________________ as other resources to be of support to me.

G. Other things I can do to help me feel stronger are ________________, ________________, and ____________________.

H. I can attend workshops and support groups at the domestic violence program or
______________________, ________________, or
______________________ to gain support and strengthen my relationships with other people.

Step 8: Items to take when leaving. When women leave partners, it is important to take certain items with them. Beyond this, women sometimes give an extra copy of papers and an extra set of clothing to a friend just in case they have to leave quickly.

Items with asterisks on the following list are the most important to take. If there is time, the other items might be taken, or stored outside the home.

These items might best be placed in one location, so that if we have to leave in a hurry, I can grab them quickly.

When I leave, I should take:

- Identification for myself
- Children's birth certificates
- My birth certificate
- Social Security cards
- School and vaccination records
- Money
- Checkbook, ATM (Automatic Teller Machine) card
- Credit cards
- Keys—house/car/office
- Driver's license and registration
- Medications

Welfare identification
Work permits
Green card
Passport(s)
Divorce papers
Medical records—for all family members
Lease/rental agreement, house deed, mortgage payment book
Bank books
Insurance papers
Small saleable objects
Address book
Pictures
Jewelry
Children's favorite toys and/or blankets
Items of special sentimental value

Telephone Numbers I Need to Know:

Police department—home
Police department—school
Police department—work
Battered women's program
County registry of protection orders
Work number
Supervisor's home number
Minister
Other

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Adapted from "Personalized Safety Plan," Office of the City Attorney, City of San Diego, California, April 1990.

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Appendix E

Hotlines and Other Resources For Domestic Violence and Related Issues

This appendix provides addresses, phone numbers, and information on three types of domestic violence organizations and groups in related fields such as rape, child abuse and neglect, and victimization. *Hotlines* provide crisis counseling and referrals to victims and those in crisis and usually supply general information either by mail or over the phone. *General resources* send bulletins, pamphlets, manuals, and other publications by mail (sometimes at cost); sometimes they give information over the phone. They also may provide additional services, such as referrals. Most of them serve the general public, although some target professionals in specific fields. The *other services* category includes research and policy groups and those that provide technical assistance, training, and advocacy. Unlike those in the previous category, *other services* tend to target professionals in specific fields, as indicated, and *are not resources for the general public.* Many of the programs and organizations listed below provide more than one type of service, so they are categorized by their primary purpose.

Hotlines

National Domestic Violence Hotline

(800) 799-SAFE
(800) 787-3224 (TDD)

Suite 101–297
3616 Far West Boulevard
Austin, TX 78731-3074

The National Domestic Violence Hotline links individuals and services using a nationwide database of domestic violence and other emergency shelters, legal advocacy and assistance programs, and social services programs. The hotline provides crisis intervention, information about sources of assistance, and referrals to battered women's shelters.

Rape, Abuse, and Incest National Network (RAINN)

(800) 656-4673

RAINN links 628 rape crisis centers nationwide. *Sexual assault survivors* who call will be automatically connected to a trained counselor at the closest center in their area.

Childhelp USA/National Child Abuse Hotline

(800) 4A-CHILD

15757 North 78th Street
Scottsdale, AZ 85260
(602) 922-8212

With a focus on *children* and the prevention of *child abuse*, this hotline provides crisis counseling, referrals, and reporting guidance to callers in crisis, including children, troubled parents, and adult survivors of abuse. All calls are answered by a staff of professional counselors. In addition, statistical and other informative materials can be ordered through this number. *Access to information on partner violence is limited.*

Childhelp, one of the largest national, nonprofit child abuse treatment and prevention agencies in the country, also runs the nation's first residential treatment facility for abused children, provides prevention services and training, and participates in advocacy and education efforts.

General Resources

American College of Obstetricians and Gynecologists (ACOG)

ACOG Resource Center
409 12th Street, S.W.
Washington, DC 20024-2188
(202) 638-5577

ACOG has patient education pamphlets and bulletins for medical professionals on both domestic violence and substance abuse.

American Medical Association (AMA)

Department of Mental Health
515 State Street
Chicago, IL 60610
Contact: Jean Owens
(312) 464-5000
(312) 464-5066 (to order resources)
(312) 464-4184 (fax)

The AMA educates physicians through publications, conferences, and by serving as a resource center for physicians and other concerned professionals. Among its publications are six diagnostic and treatment guidelines on child physical abuse and neglect, child sexual abuse, domestic violence, elder abuse and neglect, mental health effects of domestic violence, treatment and prevention of sexual assault, and media violence.

March of Dimes Birth Defects Foundation

1275 Mamaroneck Avenue
White Plains, NY 10605
Attn: Resource Center
(914) 428-7100
http://www.modimes.org

The March of Dimes provides general information on prenatal care and on the first few years of life through its resource center and its fulfillment center. *The March of Dimes does not have a hotline.*

March of Dimes Resource Center
(888) 663-4637
(914) 997-4763 (fax)
resourcecenter@modimes.org
Contact: Beverly Robertson, Director
Callers to this number can speak to someone about pregnancy, prepregnancy, drug use during pregnancy, birth defects, genetics, and other issues related to prenatal care.

March of Dimes Fulfillment Center
(800) 367-6630
Callers to this number can only place an order for materials. Two domestic violence materials are available at cost: *Abuse During Pregnancy Nursing Module,* which provides continuing education units to nurses, and a video titled *Crime Against the Future.*

National Center for Missing or Exploited Children (NCMEC)

Suite 550
2101 Wilson Boulevard
Arlington, VA 22201-3052
Hotline: (800) THE LOST, (800) 843-5678, (800) 826-7653 (TDD)
Business office: (703) 235-3900, (703) 235-4067 (fax)
http://www.missingkids.org

NCMEC leads national efforts to locate and recover missing children and raises public awareness about ways to prevent child abduction, molestation, and sexual exploitation. The hotline is available to report information on missing or exploited children or to request information or assistance. NCMEC publishes materials, including handbooks, pamphlets containing parental and professional guidelines on runaways and missing or exploited children, and publication packages aimed toward families, child care and social service practitioners, and law enforcement, legal, and criminal justice professionals.

National Clearinghouse on Child Abuse and Neglect

P.O. Box 1182
Washington, DC 20013-1182
(800) FYI-3366
(703) 385-7565
(703) 385-3206 (fax)
nccanch@calib.com

This clearinghouse offers child abuse and neglect information in the form of manuals, research reports, studies, directories, grant compendia, literature reviews, annotated bibliographies, fact sheets, database searches, CD ROM databases, and on-line services. It is sponsored by the National Center on Child Abuse and Neglect.

National Coalition Against Domestic Violence

P.O. Box 18749
Denver, CO 80218
(303) 839-1852
(303) 831-9251 (fax)

The National Coalition Against Domestic Violence serves as an information and referral center for the general public, the media, battered women and their children, and agencies and organizations. Among its purposes are to enhance coalition-building at the local, State, and national levels; support the provision of community-based, nonviolent alternatives such as safe homes and shelters for battered women and their children; provide information and referral services, public education, and technical assistance; and develop public policy and innovative legislation. The coalition maintains a public policy office in Washington, DC, and maintains a National Directory of Domestic Violence Programs.

National Sheriffs 'Association

1450 Duke Street
Alexandria, VA 22314
(800) 424-7827
(703) 836-7827

The National Sheriffs' Association has developed a handbook on victim's assistance for law enforcement officers who deal with all types of victims, including those of domestic violence. It provides training in dealing with victims sensitively, finding resources in one's community to help them, and setting up a victim assistance program.

National Victim Center (NVC)/INFOLINK

(800) FYI-CALL
(703) 276-2880
www.nvc.org

NVC operates an information and referral program called INFOLINK, which provides a toll-free source of comprehensive crime and victim-related information as well as referrals to over 8,000 victim assistance programs across the nation. Each caller can receive up to 5 of the 70 information bulletins free of charge. In addition, all INFOLINK bulletins, as well as other important information, are available on NVC's website.

Other Services

Center for the Prevention of Sexual and Domestic Violence

Suite 200
936 North 34th Street
Seattle, WA 98103
(206) 634-1903
(206) 634-0115 (fax)
cpsdv@cpsdv.seanet.com
http://www.cpsdv.org

The Center for the Prevention of Sexual and Domestic Violence is the only national organization working with and within religious communities on issues of sexual and domestic violence. Although the center's constituency includes those in the fields of law, health care, social services, counseling, and other fields, the center primarily targets religious professionals and teaches them how to effectively respond to and prevent sexual abuse and domestic violence. Services and products include trainings, workshops, and seminars; consultations; videos; specialized curriculum materials; and publications.

Colorado Coalition Against Domestic Violence

P.O. Box 18902
Denver, CO 80218
(303) 831-9632

This group does public policy work and provides community education and training, information in the form of statistics and brochures, and technical assistance to domestic violence programs.

Domestic Violence Project/Face-to-Face

(800) 842-4546

This project, sponsored by the American Academy of Facial Plastic and Reconstructive Surgery, offers free facial reconstructive surgery to anyone who has been physically disfigured due to domestic violence.

Domestic Violence Training Project (DVTP)

900 State Street
New Haven, CT 06511
(203) 865-3699

DVTP, a project for health professionals, runs enhanced education, early intervention, and advocacy programs to end domestic violence. Ongoing programs and services include seminars, conferences, consultation services, and case reviews. Project SAFE (Safety Assessment for Everyone) is an education campaign to raise health care professionals' awareness of domestic violence as a significant health problem and increase their collaboration with community-based domestic violence advocates.

Family Violence and Sexual Assault Institute

Suite 130
1121 ESE Loop 323
Tyler, TX 75701
(903) 534-5100
(903) 534-5454 (fax)
fvsai@e-tex.com

To improve networking among researchers, practitioners, and agencies, the Family Violence and Sexual Assault Institute maintains an international clearinghouse, reviews its materials, and disseminates the information through its *Family Violence and Sexual Assault Bulletin*. This independent, nonprofit corporation helps crisis centers, agencies, universities, and counseling clinics develop treatment programs for partner and sexual abuse and has published several books and bibliographies as a result of this research. The institute also provides training and consultation in the form of program evaluation, research, and technical assistance.

National Center on Elder Abuse (NCEA)

Suite 500
810 First Street, N.E.
Washington, DC 20002-4267
(202) 682-2470
(202) 289-6555 (fax)

NCEA performs clearinghouse functions, develops and disseminates information, provides training and technical assistance, and conducts research and demonstration projects of national significance. In addition, NCEA runs the country's only automated, elder abuse literature search and retrieval system. Four organizations comprise the NCEA: the American Public Welfare Association, the National Association of State Units on Aging, the University of Delaware College of Human Resources, and the National Committee for Prevention of Elder Abuse.

National Clearinghouse on Marital and Date Rape

http://members.aol.com/ncmdr/index.html

The National Clearinghouse on Marital and Date Rape provides fee-based phone consultations for information, referrals, strategies, and advocacy. The website contains fee and membership information.

National Criminal Justice Reference Service (NCJRS)

P.O. Box 6000
Rockville, MD 20847-6000
(800) 851-3420
(301) 251-5500
http://www.ncjrs.org
askncjrs@ncjrs.org

NCJRS, one of the most extensive sources of information on criminal and juvenile justice in the world, provides services to an international community of policymakers and professionals. NCJRS is a collection of clearinghouses supporting all bureaus of the U.S. Department of Justice, Office of Justice Programs. It also supports the Office of National Drug Control Policy. Information is available through information specialists, on-line services, or its CD ROM database. *NCJRS does not provide counseling or legal advice.*

National Network to End Domestic Violence

Suite 900
701 Pennsylvania Avenue, N.W.
Washington, DC 20004
(202) 347-9520

A member organization of State domestic violence coalitions, the National Network to End Domestic Violence supports 2,000 programs and services, provides training, and focuses on public policy issues.

The Domestic Violence Resource Network

The Domestic Violence Resource Network comprises four entities: the Resource Center on Domestic Violence: Child Protection and Custody; the National Resource Center on Domestic Violence; the Health Resource Center on Domestic Violence; and the Battered Women's Justice Project (a collaboration of three organizations).

Resource Center on Domestic Violence: Child Protection and Custody

Project of the National Council of Juvenile and Family Court Judges (NCJFCJ) Violence Project

P.O. Box 8970
Reno, NV 89507
(800) 527-3223
(702) 784-6160 (fax)

NCJFCJ, a national judicial membership organization, runs the Family Violence Project with the goal of developing, testing, and promoting criminal, civil, and family court procedures that better respond to domestic violence. The Resource Center, a component of the Family Violence Project, provides immediate access to information and training for judges, court workers, advocates, lawyers, child protective workers, law enforcement personnel, and other professionals dealing with child protection/custody issues in the context of domestic violence. Callers can receive accurate, up-to-date information and technical assistance over the phone or can request information packets, program materials, and other resources.

The Family Violence Project developed—through a committee of domestic violence experts including judges, attorneys, battered women's advocates, health care professionals, and law enforcement personnel—the *Model State Code on Domestic and Family Violence.* The project provides technical assistance to implement the model code.

National Resource Center on Domestic Violence

Project of the Pennsylvania Coalition Against Domestic Violence

Suite 1300
6400 Flank Drive
Harrisburg, PA 17112
(800) 537-2238
(717) 545-9456 (fax)

The National Resource Center on Domestic Violence (NRC), operated by the Pennsylvania Coalition Against Domestic Violence, is a source of comprehensive information, training, and technical assistance on domestic violence prevention and intervention. NRC serves as a central resource for the collection, preparation, analysis, and dissemination of information on domestic violence; identifies and supports the development of innovative and exemplary intervention and prevention resources; and maintains a comprehensive database of information to coordinate resource development and technical assistance throughout the nation. Although its target groups are domestic violence programs and State coalitions, NRC also serves government agencies, policy leaders, media, and other professionals and organizations involved in the prevention or response to domestic violence.

Health Resource Center on Domestic Violence

Project of the Family Violence Prevention Fund

Suite 304
383 Rhode Island Street
San Francisco, CA 94103-5133
toll free (888) Rx ABUSE, weekdays 9 a.m. to 5 p.m., P.S.T.
(415) 252-8991 (fax)
http://www.fvpf.org/health/

The Health Resource Center, which focuses on strengthening the health care response to domestic violence, provides resources and training materials, technical assistance, and information and referrals to health care professionals and others who help victims of domestic violence. Its products and services include comprehensive resource manuals providing the tools for an effective multidisciplinary response; multidisciplinary protocols emphasizing routine screening and identification of domestic violence; assistance with health care training programs and protocol development; models for local, State, and national health policymaking; a national network of experts for public speaking, training, and consultation; and educational materials specifically developed for health care providers.

Battered Women's Justice Project (BWJP)

4032 Chicago Avenue, South
Minneapolis, MN 55407
(800) 903-0111
(612) 824-8965 (fax)

The BWJP serves as a resource center and national toll-free information line regarding domestic violence issues in the criminal and civil justice systems. A collaboration of three organizations, the BWJP responds to specific requests for information or technical assistance from people who work with battered women. Each component specializes in certain areas of law and responds to questions about training, practices, and policies in those areas. BWJP develops resources such as bibliographies, various resource packets, and information about model programs, protocols, curricula, experts in the field, and training materials. The project is funded by a grant from the U.S. Department of Health and Human Services. The three organizations can be reached through the same toll-free number listed above; each has its own extension.

Extension 1:

The Criminal Justice Center—Domestic Abuse Intervention Project: for information about criminal justice responses to domestic violence.

The Criminal Justice Center responds to questions on the criminal justice system, including law enforcement, prosecution, sentencing, probation, batterer's counseling programs, coordinated community/court responses, and victim advocacy. This office also handles information requests about domestic violence and the military and intervention strategies within Native American communities.

4032 Chicago Avenue, South
Minneapolis, MN 55407
(612) 824-8768
(612) 824-8965 (fax)

Extension 2:

Civil Access and Representation Center—Pennsylvania Coalition Against Domestic Violence: For information about civil court access and legal representation issues of battered women.

The Civil Access and Legal Center aims to enhance justice for battered women and their children by increasing their access to civil court options and legal representation. With special expertise in state-of-the-art legal approaches and model protocols, legal staff provide assistance to advocates, attorneys, court personnel, and policymakers.

Suite 1300
6400 Flank Drive
Harrisburg, PA 17112
(717) 545-6400
(717) 545-9456 (fax)

Extension 3:

The Self-Defense Center—National Clearinghouse for the Defense of Battered Women: For information about issues that arise when battered women are charged with crimes.

The Self-Defense Center provides technical assistance to battered women charged with crimes and to their defense teams: attorneys, battered women's advocates, and expert witnesses; works with incarcerated battered women filing appeals or applying for parole or clemency; coordinates a national network of advocates and other professionals assisting battered women defendants; maintains a resource library of relevant articles and case law; and conducts community and professional training seminars.

Suite 302
125 South 9th Street
Philadelphia, PA 19107
(215) 351-0010
(215) 351-0779 (fax)

Appendix F
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